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Prolapse of Gastric Mucosa
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Dr. Henry Perrine
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An Editorial

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Further Observations on a New Concept of Baby Feeding

WALTER W. SACKETT, JR., M.D.
AND
BEN J. SHEPPARD, M.D.
MIAMI

The purpose of this paper is to present our further observations and findings on the continued application of "A New Concept of Baby Feeding." The first paper on this subject appeared in the August 1951 issue of The Journal of the Florida Medical Association following its presentation at a scientific meeting of the Florida Academy of General Practice. The substance of this original article is outlined in the presentation of an actual baby feeding schedule as used in our office practice (table 1).

During the year that has ensued we have continued to proceed with the further investigation of the merits of a concept embodying this six hour feeding interval with an early introduction of food. The main intent of this paper is to report on the clinical aspects of such a regimen as observed in our office practice, and also to report on the degree of acceptance and success of this concept as manifested by parent reaction to a number of questions.

A sincere effort has been made to follow weights as well as blood levels by recording both these findings on the occasion of routine office visits and at the time of special visits.

Minor changes in feeding details and closer study of records have been instrumental in modifying early impressions of trends in weight. The initial loss of weight would not seem to be as great as it was in our experience with other feeding routines, and not infrequently in an average size baby the initial loss of 4 to 6 ounces is erased by the time the baby leaves the hospital on the fourth or fifth day. For the next three to four weeks the gain in weight would seem to lag behind that to be expected at this stage of life, but thereafter the increase quickly erases this early deficit. Whereas this temporary retardation in weight increment was at one time a source of deep concern to weight-conscious parents, this concern is avoided by stressing other desired attributes resulting from this regimen.

As a matter of didactic interest, we point to one baby with a weight at birth of 4 pounds, 12 ounces who was able to follow the concept closely both as to feeding intervals and as to the addition of foods. The lowest weight encountered in any baby was in one weighing just a bit over 5 pounds at birth whose weight dropped to 4 pounds, 8 ounces before entering the phase of primary increase. It is not our purpose here to infer that this concept is applicable to premature infants; on the contrary, it was our belief that the babies mentioned were full term but small babies.

In charting blood levels we find these babies exhibit a tendency to follow closely the pattern of control babies as observed in our office practice, the controls being comprised of babies on the more conventional four hour schedule. Up until the fourth week of life they maintain a concentration of hemoglobin around 100 per cent (17.0 Gm.). This gradually drops off to a 55 to 65 per cent level at five to six months and then seems

Table 1.—Six-Hour Feeding Schedule

Feedings at 6 a.m., 12 noon, 6 p.m. and 12 midnight
Water between feedings

At 3 to 4 days old: Cereal at 6 a.m. and 6 p.m.
At 10 days old: Strained vegetables at 12 noon
(Peas, beans and carrots suggested as starters)
At 17 days old: Strained fruits at 6 p.m.
(Applesauce, peaches and pears suggested as starters)
May decrease cereal.
At 2 weeks old: Concentrated cod liver oil,
2 drops a day to start; increase 1 drop a month up to 5 drops daily.
At weekly intervals add:
3 weeks: Orange juice and sterile water, equal parts of each, up to 2 ounces of each at 6 a.m.
4 weeks: Strained meats
5 weeks: Custards
6 weeks: Soups
7 weeks: Mashed banana
8 weeks: Hard-boiled egg yolk

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From the Medical Research Unit, University of Miami, Coral Gables.

to rise slowly to a 65 to 75 per cent level, which to us is average for the children and babies in this subtropical region. Unfortunately, there have been no norms established for this subtropical climate, so that any isolated work suffers from the lack of a standard of comparison. It is our further observation that normal babies manifest these trends whether or not they are on hematinic therapy.

Questionnaire

In order to ascertain further the degree of patient acceptance and reaction to this new concept, a questionnaire (table 2) was returned by 123 mothers whose babies are being reared on this six hour accelerated schedule. Each questionnaire was accompanied by a letter appealing for unbiased answers to the individual questions.

In reply to question 1, 61 per cent of this group reported having followed the six hour schedule closely and 32 per cent moderately well. Three per cent followed it poorly and 4 per cent not at all. A more complete and universal acceptance of this prolonged feeding interval has been decidedly tempered by prejudice against any such revolutionary variation from procedures which have been standard for years. In contrast to this modified acceptance of a six hour interval on the part of the private patient stands its unquestioned, unanimous acceptance and proof of workability as proclaimed by nurses staffing a newborn nursery and by the attending personnel in an institution keeping a varying census of infants ranging from newborn to one year.

Question 2 revealed a phase of this new concept which has received practically unanimous approval from mothers. Ninety-three per cent reported following the early addition of foods closely (see feeding schedule, table 1, for details), while 6 per cent reported following their early addition moderately well. Less than 1 per cent reported following this phase poorly. These results would seem to substantiate from a practical standpoint previous scientific findings to the effect that babies can early and advantageously tolerate foods other than milk in the neonatal period and early weeks of life.

The answers to question 3 would seem to indicate little except that there is a wide latitude permitted by mothers when considering the problem of limiting their babies to a three meal routine. While the majority of mothers, namely 67 per cent, dropped the midnight feeding by seven weeks, a small per cent, 3 per cent, gave no midnight feeding at all, thus having their babies on a three meal a day schedule from birth. About 26 per cent of mothers had dropped this midnight feeding by three weeks, while a few did not drop it until the twentieth to twenty-first week.

Question 4 included a number of subquestions:

1. Fifty-two per cent of the mothers indicated that their babies sat unsupported before the age of six months; 86 per cent of the babies sat unsupported before the seventh month period.

2. Seventy-five per cent reported that their babies were able to stand unsupported within the first nine month period.

3. Sixty per cent reported that their babies walked unsupported in the ninth, tenth and eleventh month period.

4. Ninety-five per cent reported the appearance of the first tooth in the third to eighth month period, while the greatest number were reported in the sixth month.

Question 5 also included a number of subquestions:

1. Ninety-four per cent of the mothers reported that their babies took new foods more readily; 5 per cent reported in the negative with 1 per cent reporting "don't know."

2. Eighty-one per cent reported that their babies had fewer bowel upsets with 14 per cent answering in the negative and 5 per cent "don't know."

3. Seventy-eight per cent reported that their babies had fewer allergic manifestations with 15 per cent answering in the negative and 7 per cent "don't know." While this apparently great increase in the negative answer to this question might seem to indicate an argument against this feeding concept, we are more willing to believe that it results from an increasing awareness on the part of the modern parent as to what constitutes an allergic manifestation. With the newer ideas on food allergies as expressed by Rinkel, we would be inclined to reason that fewer food allergies would be produced by this method of feeding in which there is an early and pronounced rotation of foods rather than a continued feeding of a single food substance for a longer period of time.

4. Eighty-seven per cent indicated that the baby in question was a more contented baby than previous babies or those of friends or neighbors, and 12 per cent answered in the negative with 1 per cent replying "don't know."

5. Eighty-nine per cent indicated that the baby learned to amuse himself more readily, while 7 per cent answered in the negative and 4 per cent replied "don't know."

In answering question 6, 94 per cent believed that the baby in question permitted more rest and ease of mind than other siblings or babies of friends, neighbors or relatives, while 5 per cent answered in the negative, with 1 per cent replying "don't know."

Replying to question 7, 92 per cent reported that they were completely satisfied with the baby's progress, both physical and mental, on this schedule, while 7 per cent gave negative responses and 1 per cent gave a noncommittal response.

While it might be argued that all the preceding questions are based on different points of theory in this concept, question 8 pertains to the application or practicability of this concept, namely, "If you had another baby, would you rear it on this six hour schedule?" Ninety-two per cent answered in the affirmative, a response which to us is especially gratifying. Three per cent answered in the negative, and 5 per cent answered "don't know." Several of the mothers, all primiparas, explained their seemingly unfavorable answers by expressing a desire to try a future baby on one of the more standard types of feeding in order to have a basis for comparison. Unfortunately, there is no way of reporting in this paper the numerous emphatic little comments which were added to the affirmative answers. Likewise, to keep the report on the honest side, we should not fail to mention the two mothers who were equally emphatic in comments on the negative side. And to

Table 2.—Questionnaire Concerning Your Results with the New Six-Hour Accelerated Feeding Program

1. Did you adhere to the 6-hour schedule? (Check one)	Closely ☐ Moderately well ☐ Poorly ☐ Not at all ☐
2. Did you adhere to the early addition of foods? (Check one)	Closely ☐ Moderately well ☐ Poorly ☐ Not at all ☐
3. At what age did you drop the midnight feeding and place your baby on a three meal a day schedule?	.....weeks
4. At what age did your baby — sit unsupported?	.....months
— stand unsupported?	.....months
— walk unsupported?	.....months
— have its first tooth?	.....months
5. In comparison with your previous babies or with those of your friends or neighbors, do you believe that this baby — took new foods more readily?	Yes ☐ No ☐
— had fewer bowel upsets?	Yes ☐ No ☐
— had fewer allergic manifestations?	Yes ☐ No ☐
— was a more contented baby?	Yes ☐ No ☐
— learned to amuse himself readily?	Yes ☐ No ☐
6. Do you think that this baby permitted you more rest and ease of mind than your other babies or those of your friends, neighbors or relatives?	Yes ☐ No ☐
7. Were you completely satisfied with your baby's progress, both physical and mental, on this schedule?	Yes ☐ No ☐
8. If you have another baby, would you rear it on this 6-hour accelerated schedule?	Yes ☐ No ☐

Please give here any comments or further information regarding your baby (blood counts, if any, serious illnesses and suggestions):

(Continue on back of this sheet)

Parent's Name.....

Baby's Name.....

Mailing Address.....

.....

Sincerely,

Walter W. Sackett, Jr., M.D.
Ben Sheppard, M.D.
Research Associates, Medical
Research Unit, University of Miami

be scrupulously honest, one of the mothers giving a negative reply admitted in a postscript that had her husband filled out the questionnaire, he would definitely have been for the program. Her negative answers to these questions were based on her inability to nurse her baby, which she attributed to the six hour interval. We believe that her thoughts regarding breast feeding were erroneous, as will be explained in a subsequent paragraph. Even though this report fails to encompass much more than one and a half to two years of trial, one mother who subsequently moved to Illinois emphasized her favorable answers to these questions by stating that she is rearing a second baby on this schedule despite the fact that the baby is under the care of another physician in a distant state.

The question as to the adaptability of breast feeding to this program often arises. During World War II one of us often was asked if a working mother could nurse her baby morning and evening and leave a noonday bottle for her baby. It was found that this arrangement would work admirably, thus permitting an interval of between eight and 12 hours between breast feedings. This principle of natural adaptation of the flow of milk to the demand for milk works equally as well with nursing mothers on the six hour schedule. Furthermore, the long night interval, whether the baby is on a six hour or four hour schedule, would tend to prove that mothers could go for equally as long intervals during the day.

It has been reported to us by physicians in various parts of the country that they have had only fair results with this schedule. We should like to state that there are countless numbers of circumstances which mitigate against the acceptance of this concept of baby feeding. They would include the wide publicity by lay publications given to the demand type of feeding plus the willingness on the part of neighbors, grandmothers and friends to explain any upsets on the part of the baby on the basis of whatever feeding regimen is being carried out. One of us, engaged in general practice, makes a sincere effort to indoctrinate his obstetric patients along the lines he has in mind during the pregnancy. Considerable time is taken upon discharge from the hospital to explain this schedule thoroughly to the mother and to encourage her to start on this schedule. It is our opinion that, were we able to spend additional time with the mothers when they are faced with minor problems at home, we could increase substantially the number of mothers who would accept this six hour schedule.

On numerous occasions we have been accused of omitting from this schedule a most important element in the emotional development of a baby, namely, parental love. On the contrary, we urge parents to manifest an ample supply of this emotion by loving, cuddling, playing with and even rocking the infant at frequent intervals, but only when the baby is awake and not crying, rather than when he is crying. Indeed, it is the admonition of one of us that he would prefer to awaken the baby from a sound sleep for the display of such an emotion rather than to demonstrate it during a crying episode on the part of the baby.

In conclusion, it is our opinion from a medical standpoint as based on accurate records and clinical observations of these babies that in health, development, both mental and physical, and general well-being they are on a par with those babies brought up on the more generally accepted theories of baby feeding. We believe, however, that the main advantage in this schedule lies in the contribution to the mother's stability, which in turn is reflected in a baby who will present fewer feeding problems during the ensuing years of life. In addition to there being a better level of adjustment between the mother and the baby, the application of this concept of feeding permits a mother to devote more time to the remaining family obligations. As these babies progress into a more advanced state of childhood, impressions continue to mount to the effect that babies reared on a schedule such as embodied in this new concept are a happy and contented lot, in direct contrast to those babies subjected to a demand schedule, who seem to develop constantly along "demanding lines." Our observations would tend to serve as a direct refutation to the thoughts of the modern child psychologist, who might be tempted to label babies fed on a six hour schedule as "thwarted individuals" with an assured impaired psychiatric outlook on life.

Summary

A trial of almost two years of a new concept of baby feeding, involving an initial six hour feeding interval for babies from birth with an early introduction of foods, would tend to prove by the accepted criteria a degree of workability and acceptance far beyond expectations anticipated at its inception. These favorable results apply not only to the baby but to the mother as well.

Acknowledgment is made of a quantity of homogenized foods made available for this program by Lilly, McNeill & Libby of Chicago.

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2500 Coral Way.

Prolapse of the Gastric Mucosa into the Duodenum: Report of Eight Cases

Sidney Stillman, M.D.
Jacksonville

Prolapse of the gastric mucosa into the duodenum, though once considered rare, has been diagnosed frequently in the past few years. The syndrome was originally described by Schmieden[1] in 1911. It was not recognized in this country until 1925 when Eliason and Wright[2] presented a case. A review of the literature up to the present time reveals that over 100 cases have been diagnosed roentgenologically and at least 44 cases have been proved by surgery. The following is a list of a few of the reported cases in addition to those mentioned: Eliason, Pendergass and Wright,[3] 2 cases in 1926; Meyer and Singer,[4] 1 case in 1931; Shiflett,[5] 1 case in 1932; Meyer,[6] 1 case in 1935; Pendergass and Andrews,[7] 3 cases in 1935; Rees,[8] 4 cases in 1937; Bohrer and Copleman,[9] 1 case in 1938; Archer and Cooper, [10] 4 cases in 1939; Rubin,[11] 1 case in 1942; Melamed and Hiller,[12] 1 case in 1943; Norgore and Shuler,[13] 1 case in 1945; MacKenzie, Macleod and Bouchard,[14] 2 cases in 1946; Scott,[15] 14 cases in 1946; Appleby,[16] 6 cases in 1947; Judd and Moe,[17] 1 case in 1947; Nygaard and Lewitan,[18] 1 case in 1948; DiLeo, Kuker and Shepard,[19] 1 case in 1948; Manning and Highsmith,[20] 16 cases in 1948; Ellison and Squire,[21] 5 cases in 1949; Cove and Curphrey,[22] 22 cases in 1949; and Kaplan and Shepard, [23] 3 cases in 1951. During a period of five years, I have observed 8 cases which have been diagnosed roentgenologicaly. Surgical confirmation was not obtained, as in no case were the symptoms severe enough to warrant exploration.

Etiology

The etiology of the condition is not definitely known, but several theories have been propounded. Eliason and Wright[2] postulated that chronic irritation of the gastric mucosa due to physical, nutritional, chemical, functional, or bacterial causes might result in chronic inflammation and hypertrophy. The latter are further increased by peristalsis of the stomach and gastric contents. Golden[24] and Forssell[25] studied the gastric mucous membrane. Golden's studies of antral systole threw further light on the possible etiology of the condition by his observation that in some cases the mucosal folds run transversely to the long axis of the stomach, and during antral systole these assume a longitudinal course and may move cephalad. Should this cephalad movement fail to occur in antral systole, the mucosa is forced by pressure through the pyloric canal. Rees[8] proposed that there is first a narrowing of the pylorus, and this is followed by hyperperistalsis in an effort to force the contents through the narrow opening. The attachment of the mucosa to the muscularis becomes loosened and subject to trauma, resulting in hypertrophy and prolapse. MacKenzie, Macleod and Bouchard[14] did not support any of these theories, but were of the opinion that emotional factors precipitate the condition. Scott[15] considered the conditions necessary for prolapse to be inherent in the normal stomach, with prolapse only occuring after the flexible fibers of the submucosa have become stretched and loosened by abnormal peristalsis. This, in time, is initiated by neurogenic or chemical stimuli or a combination of both. Manning and Highsmith[20] emphasized the importance of chronic hypertrophic gastritis from any cause involving the antral mucosa. The interference with the normal mechanism of antral systole will result

in the development of prolapsing redundant mucosa in a majority of the cases.

Symptoms

There is no symptom complex characteristic of the disease, and it is rarely diagnosed before roentgen study. The symptoms include intermittent epigastric distress, fulness, gaseous distension, nausea and vomiting. Obstructive symptoms with distress after eating were noted by Rees.[8] In several cases reported in the literature gross hematemesis occurred. Pendergass and his associates[3,26] stressed the incidence of secondary anemia of a severe grade due to ulceration and oozing. The discomfort lacks the periodicity of peptic ulcer. Eliason and Squire[21] were impressed by the cramplike distress in the epigastrium of varying severity and generally worse under nervous tension. One should suspect the condition in any atypical history of ulcer.

Incidence

The condition is apparently most common in the fourth and fifth decades. A review of 44 cases in which the patient was operated upon revealed 28 males and 16 females. Except for peptic ulcer and gastritis, gastric mucosal prolapse is the most important of the benign conditions affecting the distal end of the stomach and the duodenal bulb.

Pathology

Manning and Gunter[27] were able to study the gross and microscopic pathologic manifestations in 6 cases. In 5, there was mild to severe gastritis. Grossly and microscopically, the gastritis appeared to be of the hypertrophic type except in 1 case in which atrophic changes predominated. In 4 cases the submucosa was unusually loose so that it appeared as a tonguelike polypoid fold protruding through the pylorus.

In 1 case the prolapsed mucosa was a hypertrophied fold which was forced caudally into the duodenum by the hypertrophied pyloric muscle. The pyloric muscle was thickened, and the pyloric channel appeared narrowed in 4 cases. The muscularis mucosae was thickened in 3 cases and showed myelocystic infiltration in 1 case. The prolapse may be unilateral or circular and complete. In the unilateral type a portion of the prepyloric gastric mucosa slips into or through the pyloric canal presenting itself on one side of the base of the duodenal bulb projecting into the lumen. The pyloric sphincter contracts on the mass, the end of which becomes swollen and engorged while the portion in the canal is stretched out. In the circular type there is complete separation of the prepyloric mucosa from its muscularis. The mucosa slides through the pylorus in the form of a cylinder propelled by peristalsis and may remain fixed there in a manner similar to a small intestinal intussusception. The cylinder of tissue presents in the base of the bulb of the duodenum, and a central depression marks the pyloric canal. Studies of the gastric analysis for acidity were not consistent. Gastric acidity from 0 degrees free and 13 degrees total to 75 degrees free and 90 degrees total has been reported.

Roentgen Diagnosis

The roentgenologic appearance of this condition was described vividly by Eliason, Pendergass and Wright.[3] They described a central, circular, or irregular circular filling defect in the duodenum, usually at the base of the duodenal bulb, with elongation and narrowing of the pyloric channel. The extent of the defect is governed by the amount of prolapsed mucosa. One rarely discovers it in the erect position — most often in the horizontal and right oblique position. A six hour residue is frequent. The stomach may appear normal, but usually long mucosal folds are found in the antrum associated with antral spasm. In many cases Manning and Highsmith[20] reported a rather constant "umbrella" or "mushroom" deformity in the base of the duodenal cap as the most characteristic roentgenologic finding with or without elongation and narrowing of the pyloric channel and increase in the size of the rugae of the pylorus and antrum. This condition has to be differentiated from pyloric ulcer, hypertrophic gastritis, prolapsing gastric polyps, duodenal polyps and carcinoma of the stomach. A definite diagnosis can only be made by exploratory laparotomy.

Treatment

In all cases of prolapsed gastric mucosa the patient should be given the benefit of medical treatment initially. The medical regimen recommended is a bland diet, antiacids, antispasmodics and mild sedation. One should endeavor to have the patient avoid emotional tension and all contributing factors such as smoking, alcohol, chronic respiratory infections and dental caries. In a majority of cases it is a reversible state, and surgery is not indicated. If no improvement is ascertained in a month's rigid medical treatment, surgery should be contemplated. Several operations are

suggested and performed. The operations generally used include excision of the redundant mucosa and pyloroplasty, gastric resection, gastroenterostomy, simple excision of redundant mucosa, excision of the mucosa and gastroenterostomy, pyloroplasty and closure of the pylorus and gastroenterostomy. Kaplan and Shepard[23] reported 4 surgical cases. In 1 a Heineke-Mikulicz pyloroplasty was performed, in 2 excision of redundant mucosa and a Heineke-Mikulicz pyloroplasty, and in the fourth a simple excision of redundant mucosa. The results were good in the first type of surgery. In the second type the results were excellent in 1 case, and in the other the patient died of complications. In the fourth case a gastroenterostomy was necessary at a later date.

Report of Cases

Case 1. — H. S., a white man aged 44, complained in June 1948 of epigastric distress for the past six months. The pain was "aching" in character, lasted ten to fifteen minutes, usually appeared two hours after eating, and was relieved by eating or belching. He vomited occasionally, but no blood was in the vomitus. Physical examination and blood studies gave essentially negative results. Roentgen examination revealed a constant deformity of the antral portion of the stomach with a constant niche. The patient was treated with antispasmodics, diet and sedatives. When roentgen examination was repeated in July, there was evidence of widening of the pyloric canal, which was attributed to hypertrophy of the sphincter, as well as thickening of the mucosa with slight prolapse into the duodenal bulb (fig. 1). The constant niche had disappeared. The last roentgenograms, in January 1950, showed some widening of the pyloric channel still present, but considerable improvement of the prolapse. The patient is comfortable as long as he continues the ulcer regimen.

Figure 1

Case 2. — A. Z., a white man aged 43, in December 1948 gave a history of having eaten some highly seasoned salad the day before, and as a result he had severe "heartburn." He had taken an effervescent alkalinizing analgesic preparation which had relieved the condition to a slight extent. Physical examination was essentially negative except for moderate hypertension. Laboratory tests were noncontributory. Roentgenograms of the stomach revealed heavy rugae formation in the antrum of the stomach, and the duodenal cap showed a typical mushroom type of filling found in a prolapse of the mucosa through the pylorus (fig. 2). The patient was treated with antiacids, antispasmodics, sedatives and a bland diet. He was symptom-free as long as he continued this regimen. Roentgenograms in January 1951 still showed a normal duodenal cap except for indentation at the base, attributed to pressure from the pyloric muscle and possibly a slight degree of prolapse of the haustral mucosa.

Figure 2

Case 3. — J. G., a white man aged 43, related on Sept. 19, 1949, that on several occasions in the past three months he had been awakened from a deep slumber with a feeling of fulness and giddiness in the stomach. He found belching or vomiting would give him relief. There was no relation to types of foods nor to time of eating. Physical examination revealed tenderness in the epigastric area. Laboratory examinations, including a complete blood count,, urinalysis, sedimentation rate, fasting sugar, and stools gave negative results. Roentgenograms of the stomach showed heavy rugae formation in the antral portion, but no constant filling defect. At times a definite mushroom type of filling was seen in the duodenal cap (fig 3). On an ulcer regimen the patient showed some improvement, but continued to have occasional attacks of a similar nature and refused to consider surgery.

Case 4. — B. W. C., a white man aged 58, in April 1950 gave a lengthy history of "stomach" distress, relating that he had been subjected to roentgen examination at least twice a year for the past five years. His complaints consisted of slight pain in the epigastric region and bloating, which were aggravated by tension. He had tried every kind of ulcer regimen with little relief, and concluded that sedatives gave him maximum relief. Physical examination gave negative results except for slight tenderness along the descending colon. An alkaline tide test revealed excessive acidity. Electrocardiographic and other laboratory tests were not significant. Roentgenograms taken at this time showed the antral rugae to be exceptionally heavy and some mushrooming into the duodenal cap due to prolapse of the gastric mucosa through the pylorus (fig. 4). The patient was instructed concerning his condition and again given a bland diet, antiacids, antispasmodics and sedatives.. On this occasion he was relieved to a great extent, the reason for which I cannot explain. Roentgenograms of the gastrointestinal tract were again taken in February 1951, and the same condition was apparent.

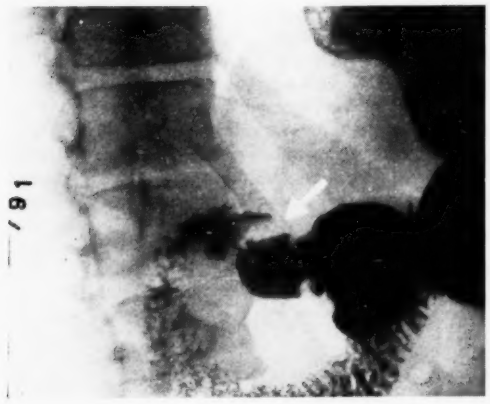

Figure 3

Figure 4

Case 5. — E. L., a white woman aged 40, stated in February 1951 that she had been having severe "indigestion." For the past three months she had observed that the consuming of food or belching would alleviate the discomfort. Fried and highly seasoned foods would aggravate the symptoms. Physical examination revealed slight tenderness in the epigastric area. No masses could be felt. Laboratory examinations gave negative results, but roentgenograms of the upper part of the gastrointestinal tract showed a prolapse of the gastric mucosa through the duodenal cap, giving a mushroom type filling (fig. 5). This patient responded significantly to an ulcer regimen.

Case 6.—H. D., a white man aged 23, in March 1951 complained of "hurting in the pit of the stomach" and stated that he had been awakened from a profound sleep with this discomfort. He would often vomit bile-tinged material and was continually belching. He had been under a great deal of stress of late precipitated by his second matrimonial venture. Physical examination gave essentially negative results. Gastric analysis with 7 per cent alcohol gave a maximum acidity of free 35 degrees, total 55 degrees. Other studies were noncontributory. Roentgenograms of the upper part of the gastrointestinal tract revealed some spasticity in the antral portion of the stomach and evidence of prolapse of the gastric mucosa into the duodenal cap (fig. 6). The patient has had alleviation of distress since he has adhered to a bland diet, antispasmodics and antiacids.

Case 7. — E. C. I., a white man aged 56, on his initial visit gave a lengthy history of "heartburn." The discomfort would awaken him at night, and he believed that food aggravated the condition. He was taking milk of magnesia tablets excessively with slight relief. Physical examination revealed tenderness of considerable degree in the epigastric area as well as over the gallbladder. Laboratory observations were noncontributory. Roentgenograms of the intestinal tract showed that the antral rugae were somewhat heavy with slight indentation into the duodenal cap, characteristic of early prolapse of the gastric mucosa into the duodenal cap (fig. 7). The symptoms were slightly improved on an ulcer regimen.

Case 8.—I. E., a white man aged 39, was seen initially in May 1948, at which time he gave a history of "stomach" trouble for the past ten years. When the discomfort first started he would get dull pains in the "pit" of the stomach, especially during periods of emotional stress. He was immediately relieved with dieting and antiacids. While in service in 1944, he had a gastric hemorrhage. All procedures including roentgenograms gave negative results. At the time of his discharge from the Army in 1946, roentgen examination was again repeated, but gave no evidence of pathologic change.

Figure 5

Figure 6

Physical examination on the initial visit gave negative results. A gastric analysis with 7 per cent alcohol gave a maximum acidity of free 42 degrees, total 75 degrees. The results of other laboratory procedures were essentially negative, and roentgen examination of the gastrointestinal tract also gave negative results.

In August 1951, the patient reported having had severe nausea for several days. While at the theater he became weak and on arriving home evacuated "tarry stools." He was hospitalized, and on examination the stools exhibited definite evidence of blood. The hemoglobin estimation was 72 per cent, whereas on all previous occasions it had been in the nineties. Treatment consisted of absolute bed rest and the Sippy routine. After several days a roentgenogram of the upper part of the gastrointestinal tract was ordered. The roentgenologist on this occasion reported that the distal portion of the antrum showed evidence of mucosal hypertrophy with invagination into the base of the duodenal bulb (fig. 8). The patient responded excellently to ulcer regimen and hematinics.

Summary

Eight cases are reported in which the clinical and roentgenologic findings were consistent with a diagnosis of prolapse of the gastric mucosa through the duodenum.

The condition is not a rarity if one bears it in mind.

One finds it more prevalent in the older age group and principally in males.

No definite conclusion can be made as to the specific etiology.

Figure 7

In all cases the patient should have the benefit of a medical regimen; and if relief is not obtained, one should consider surgery.

When surgery is definitely indicated, excision of the redundant mucosa with pyloroplasty is recommended.

The roentgenograms were made available through the courtesy of Drs. H. Bernard McEuen, Floyd K. Hurt and Wade S. Rizk.

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Figure 8

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Incidence of Heart Disease in School Children of Pensacola, Florida

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PENSACOLA

In 1949 a study of the cardiovascular status of school children in Pensacola, Fla., was undertaken by the Naval School of Aviation Medicine in conjunction with the Florida State Board of Health. The purpose of this study was twofold: first, to determine the types and incidence of heart disease in a representative sample of school children residing in Northwest Florida, and second, to establish standards for the electrocardiogram and for heart size in healthy persons 10 to 20 years of age. This report will include a description of materials and methods used in the study and a presentation of the findings in the cases of heart disease. Subsequent reports will present an analysis of the electrocardiographic and roentgenographic findings in the children without heart disease.

Description of Pensacola and Its School System

Pensacola is situated on the Gulf of Mexico near the northwest border of Florida at a latitude of 30 degrees 25 minutes north and a longitude of 87 degrees 13 minutes west. The elevation of the major part of the town is 12 feet above sea level. The annual rainfall over the past 71 years has averaged 59.5 inches. The mean temperature is 67.8 F., varying from a mean temperature in the winter of 54.3 F. to a mean summer temperature of 80.5 F. The population of Pensacola proper in the 1950 census was 43,263. If the surrounding communities are included, the population of greater Pensacola is 76,700. The city is situated in Escambia County, which has a population of 112,756 (ranking ninth in the state) and an area of 608 square miles (ranking thirty-eighth in area).

The public school system for white children in Pensacola is composed of one high school, two junior high schools, and six elementary schools. Three schools were selected for the survey: the high school, which serves the surrounding communities as well as the city proper; the larger of the two junior high schools, which draws its students from within the city limits from a slightly lower socioeconomic group than the nonsurveyed junior high school; and the largest of the six elementary schools, which is situated in the same geographic region and serves the same families as the selected junior high school. The survey did not include parochial schools nor schools for Negro children.

Materials and Methods

In so far as possible, every student in each school selected was examined, except in the elementary school where only the children in grades 4, 5, and 6 were included in the survey. Out of a total enrolment of 2,657 in the grades selected, 2,600 (98 per cent) were examined; 2,560 by the senior author and the remainder by a second examiner. The age and sex distribution is shown in table 1. Boys comprised 51.6 per cent of the total. The ages ranged from 9 to 23 years with the mode at 16 years and the mean and median ages at 14.7 years.

There were 55 students who refused to cooperate in the study despite appeals made through

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Table 1.—Age and Sex Distribution of Examined Children

Age	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
Boys	19	42	38	107	165	149	221	253	225	96	14	6	4	0	2	1,341
Girls	17	38	49	133	147	164	190	213	235	56	12	4	1	0	0	1,259
Total	36	80	87	240	312	313	411	466	460	152	26	10	5	0	2	2,600

their parents and family physician. In as many instances as possible, the records of the family physician were examined to determine the presence or absence of heart disease. In only 1 case was there a history of heart disease, and this case is not included in the survey. Two other students moved from Pensacola before satisfactory roentgenograms could be obtained; although the remainder of the examination was normal, they have been excluded from the total.

The parents were requested to complete a questionnaire giving details of the student's birth, past health, and the name of the family physician, if any. At the time of the examination the salient features of this questionnaire were reviewed by the examining physician, and the student was questioned regarding any symptoms of cardiovascular origin. The physical examination included measurements of height, weight, anteroposterior and transverse diameters of the chest at the level of the xiphoid process, and the blood pressure determined with the patient seated. In addition an estimate was made by the examining physician of the student's state of sexual development, which was classified as prepuberal, puberal, or postpuberal. Because of the possible effects of anxiety and overventilation on the blood pressure and on the electrocardiogram,[1,2] the mental attitude of the child was also estimated and recorded as either relaxed, moderately tense, or definitely anxious. A brief general physical examination was then performed, followed by a detailed examination of the lungs and heart; the latter was examined with the subject in both the sitting and recumbent positions. The left lateral decubitus position after exercise was used in students with a past history of rheumatic fever, in those with a loud mitral first sound or with a third sound in diastole simulating the opening snap of mitral stenosis, and in students with loud or well transmitted apical systolic murmurs.

Laboratory examinations included a six-foot roentgenogram of the chest and two electrocardiograms. The first electrocardiogram was taken with a Sanborn Viso-cardiette. Leads 1, 2, 3, aVR, aVL, aVF, and V_{1-6} were obtained. This record was reviewed immediately and a brief interpretation entered on the data sheet. The second electrocardiogram was then obtained with a Sanborn Cardiette, and, in addition to the twelve leads mentioned, CF and V leads obtained from points in the left paravertebral line at the level of V4, 5, and 6 were recorded for use in vector analysis. In selected cases a more complete electrocardiographic exploration was carried out.

At a later date a clinical interpretation was made of the roentgenogram and electrocardiogram, and in case of technical error an additional record was obtained. Quantitative measurements were made subsequently. All interesting and abnormal electrocardiograms were reviewed by the entire staff at the cardiovascular laboratory of the Naval School of Aviation Medicine; problems of interpreting the roentgenograms were referred to Naval or civilian consultants.*

When, on physical examination, the findings were definitely or possibly abnormal, or the roentgenogram or electrocardiogram suggested that some abnormality had been overlooked, the subjects were re-examined by at least two physicians. At this time a definite decision could usually be reached regarding the presence or absence of heart disease. In certain problem cases further roentgen, electrocardiographic, or laboratory studies were carried out.

The diagnosis of rheumatic heart disease was made only in the presence of characteristic murmurs. Aortic insufficiency was diagnosed when a blowing diastolic decrescendo murmur was heard along the left sternal border or in the second right interspace. Aortic stenosis was diagnosed in the presence of a harsh, grade 2 or louder systolic murmur in the second right interspace transmitted to the neck, when other murmurs characteristic of

*We are grateful to Dr. Nathan Arenson, Captain C. C. Virtue, MC, USN, and Commander Curtis Asher, MC, USN, for their advice and aid during this study.

rheumatic heart disease were heard. In the absence of other murmurs of rheumatic heart disease, aortic stenosis was not diagnosed unless a thrill was present. Mitral stenosis was diagnosed in the presence of a low-pitched, rumbling, middiastolic apical murmur, with or without presystolic accentuation. Mitral insufficiency was diagnosed in the presence of an apical systolic murmur of grade 3 intensity or louder which was transmitted toward the axilla and which did not disappear with change in body position or respiration. The diagnosis of mitral insufficiency was made in the absence of roentgenographic evidence of enlargement of the heart if there was a history of previous rheumatic fever.

Congenital heart disease was diagnosed when grade 3 or louder systolic murmurs were heard over the base of the heart or along the left sternal border, which persisted despite changes in respiration or body position. Abnormalities of the roentgenogram or electrocardiogram were considered additional evidence in favor of the diagnosis. Cases of the Wolff-Parkinson-White syndrome were classified as cases of congenital heart disease even though the roentgenogram and physical examination revealed no abnormalities. Care was taken to avoid mistaken diagnoses of heart disease based on insufficient evidence.

After the roentgenogram and electrocardiogram had been interpreted in the light of clinical findings, a report was sent to the family stating either that no abnormalities were found, or that abnormalities existed and that the family physician should be consulted. In all cases, both normal and abnormal, the family physician received a brief report of the medical, roentgenographic and electrocardiographic findings together with a portion of the Viso-cardiette record for his files.

Table 2.—Incidence of Heart Disease in School Children of Pensacola, Florida

	Number	Per Cent
Total number examined	2,600	100.00
Organic heart disease*	22	0.85
Chronic rheumatic heart disease 10 cases (0.38%)		
Congenital heart disease 10 cases (0.38%)		
Unknown etiology 2 cases (0.08%)		
Possible heart disease	4	0.15
Potential rheumatic heart disease	15	0.57
Potential syphilitic heart disease	1	0.04

*See footnote, page 33.

Results

Twenty-two of the 2,600 school children examined had definite heart disease, an over-all incidence of 0.85 per cent. Ten of the 22 had inactive rheumatic heart disease (0.38 per cent), 10 had congenital heart disease (0.38 per cent), and 2 had isolated aortic stenosis which, in the absence of a history of rheumatic fever, could not be definitely distinguished from congenital subaortic stenosis (table 2). The pertinent clinical data are given in tables 3-6. It should be noted that 2 of the cases in which the diagnosis was inactive rheumatic heart disease with mitral insufficiency would be called cases of "potential and possible rheumatic heart disease" according to the criteria of the New York Heart Association[3] because of the absence of cardiac enlargement. It is our opinion that these 2 cases, in each of which there was an undoubted history of acute rheumatic fever and a loud, harsh, holosystolic murmur transmitted to the axilla (which in 1 case had been heard over an

Table 3.—Summary of Case Histories of Children with Chronic Rheumatic Heart Disease

Case Number	Sex	Age	Years in Pensacola	History of Rheumatic Fever	Valvular Lesion	Cardiac Enlargement by Roentgenogram	Electrocardiographic Findings	Previously Diagnosed
119*	F	17	17	Yes	MI	No	Normal	Yes
173	M	17	6	No	AI, MI	No	LAD	No
194*	F	17	2	Yes†	MI	No	Normal	Yes
625	F	17	16	No	MI	Yes	Increased voltage in chest leads	Yes
1,256	F	17	9	Yes	MI	Yes	1° A-V block	Yes
1,266	F	17	17	No (RA)	MI, MS	No	Normal	No
1,271	F	18	18	No	MI	Yes	Increased voltage in chest leads	No
1,509	M	16	16	Yes	AS, MI	No	PVB's	Yes
1,763	M	14	2	Yes†	AI	No	Normal	Yes
2,451	M	14	14	Yes	AI, MI	No	Normal	Yes

*Cases 119 and 194 would be diagnosed potential and possible rheumatic heart disease according to criteria of New York Heart Association. See text.

†Rheumatic fever before coming South.

Abbreviations used in this table: F—female, M—male, MI—mitral insufficiency, AI—aortic insufficiency, MS—mitral stenosis, AS—aortic stenosis, LAD—left axis deviation, PVB's—premature ventricular beats, and RA—rheumatoid arthritis.

Table 4.—Summary of Case Histories of Children with Congenital Heart Disease

Case Number	Sex	Age	Years in Pensacola	Presumptive Diagnosis	Cardiac Enlargement	Electro-cardiographic Findings	Previously Diagnosed
227	M	17	2	IASD	Yes	RBBB	Yes
402	M	16	8	IASD	Yes	Incomplete RBBB	Yes
566*	M	17	17	WPW	Yes	Short P-R, prolonged QRS	No
734*	M	16	16	WPW	No	Short P-R, slurred QRS	No
832*	F	15	15	WPW	No	Short P-R, slurred QRS	No
839*	M	17	17	WPW	No	Short P-R, prolonged QRS	No
885	M	17	17	IVSD	Yes	Slight LAD	Yes
1,232	F	16	16	IVSD	Yes	Incomplete RBBB	Yes
1,678	M	12	12	IVSD	No	Slight LAD	Yes
1,757	M	16	16	IASD	Yes	RAD	No

*See footnote this page.
Abbreviations used in this table: IASD—interauricular septal defect, IVSD—intraventricular septal defect, WPW—Wolff-Parkinson-White Syndrome, RBBB—right bundle branch block, LAD—left axis deviation, and RAD—right axis deviation.

11 year period), are more properly classed as cases of definite heart disease. It should be noted also that we have included among the cases of congenital heart disease 4 cases of the Wolff-Parkinson-White syndrome*

Four additional cases were classified as cases of possible heart disease. In 2 there was first degree heart block according to the criteria of Ashman and Hull[4] with a doubtful history of rheumatic fever: one child had a "weak heart caused by tonsils" at age 12; the other had had fever of unknown origin during which the possibility of rheumatic fever was raised despite the absence of joint pains, rash, nosebleeds and chorea. In 2 other cases there were moderately loud systolic murmurs heard maximally in the third left intercostal space near the sternal border which were well transmitted to the base but which varied markedly, although they did not disappear, with change in body position and respiration. In each case the roentgenogram and electrocardiogram were normal, and the past history was noncontributory.

The diagnosis of potential syphilitic heart disease was made in one 15 year old girl with an apparently normal cardiovascular system, who had recently completed a course of penicillin therapy for acquired syphilis. No other persons gave a history of syphilis. Since a serologic test for syphilis was not performed as part of this survey, it is possible that some cases were overlooked.

In 15 cases in which there was no evidence of heart disease, a well substantiated history was given of one or more attacks of acute rheumatic fever. In these cases the diagnosis was potential rheumatic heart disease, and the families were urged to continue to have the children examined annually. In 9 other cases in which heart murmurs were not present, the parents reported that rheumatic fever had been suspected or diagnosed, but the history of the symptoms or of the treatment, or both, when obtained during the present survey made that diagnosis seem unlikely. It is appreciated that the diagnosis of acute rheumatic fever is often difficult and that many cases occur which are unrecognized. Nevertheless, if a diagnosis of rheumatic fever is seriously entertained by a physician, bed rest of more than a few days should be enforced. Since in these 9 cases prolonged bed rest had not been required, they have not been recorded as cases of potential rheumatic heart disease.

A history of diphtheria was obtained in 44 cases. Since it is doubted that cardiac sequelae can arise after a period during which the heart is normal,[5] these cases are not classified as cases of potential heart disease.

Certain other miscellaneous conditions are worth mentioning. One 17 year old girl with an otherwise normal heart had paroxysmal ventricular tachycardia which reverted to normal only with procaine amide or quinidine therapy. Two girls, who were first cousins, had depressed ST seg-

*In order to facilitate comparison with other surveys, we append the incidence of heart disease when the 2 cases of mitral insufficiency without cardiac enlargement and the 4 cases of the Wolff-Parkinson-White syndrome are not included:

Disease	Cases	Per Cent
Rheumatic heart disease	8	0.31
Congenital heart disease	6	0.23
Unclassified heart disease	2	0.08
Total	16	0.62

Table 5.—Summary of Case Histories of Children with Heart Disease of Undetermined Etiology

Case Number	Sex	Age	Years in Pensacola	History of Rheumatic Fever	Valvular Lesion	Cardiac Enlargement	Electro-cardiographic Findings	Previously Diagnosed
326	M	16	16	No	AS only	No	Early LVH (?)	No
1,650	M	15	1	No	AS only	No	Normal	No

Abbreviations used: AS—aortic stenosis, and LVH—left ventricular hypertrophy.

ments, which proved to be a familial abnormality.[6] Twenty-eight children showed various degrees of "local T negativity"[7] in the precordial leads. A number of children had funnel chest (pectus excavatum) with apparent enlargement of the heart demonstrated roentgenologically. In several other children the heart was more than 10 per cent enlarged, as shown by teleroentgenogram, without evident cause. These various groups will be discussed in more detail in subsequent reports.

Certain noncardiac diseases were encountered: minimal tuberculosis (1 case); fibrosis of the lung (1 case); undiagnosed consolidation or calcification (4 cases); dyschondroplasia (1 case), and many cases of benign skin disorders. In these cases, the patients were referred to their family physician for further diagnosis and treatment.

Discussion

Close comparison is impossible among the numerous surveys of heart disease in school children for several reasons. The most important is the failure of many authors to state the criteria used for the selection of subjects and for the diagnosis of heart disease, especially mitral insufficiency. The different backgrounds of the examiners and the varying use of laboratory aids in the survey also make direct comparison of results difficult, as Wedum, Wedum and Beaghler[8] emphasized. The age range of the children also affects the incidence of heart disease: Young[9] in a survey of school children in Salt Lake City found a rate of 27 cases of rheumatic heart disease per thousand in the 10 to 12 year age range, while Alway,[10] using the same criteria in the same city, found 7 cases per thousand in the 15 to 18 year group. This apparent discrepancy is resolved when the figures are viewed in the light of Jones' report[11] that 20 per cent of the children with rheumatic heart disease in his series died before age 18 and that 64 per cent of those remaining showed no, or minimal, evidence of heart disease. Finally, the number of children surveyed must be taken into consideration, for in a study of a small number of students the addition or subtraction of 1 case of heart disease may profoundly affect the rate per thousand. Until large numbers of randomly selected children are examined by cardiologists using clearly defined criteria, the incidence of heart disease in children cannot be estimated with accuracy.

Despite these difficulties in comparing the reported surveys of heart disease in school children, certain general trends are evident. The incidence of rheumatic heart disease varies widely from locality to locality; this disease is more prevalent in cold moist climates and among children living under unfavorable conditions. The variation in the incidence of congenital heart disease is considerably less, a difference which is not surprising in view of what is known etiologically of these conditions. It is also noteworthy that in the studies reporting the highest incidence of congenital heart disease, the lowest total number was examined.[12,13]

When our results are compared with those of the surveys conducted by other cardiologists (table 7), it is evident that the incidence of rheumatic heart disease in Pensacola is in the same range as the reported incidence in Miami, Fla.,[13] South-

Table 6.—Summary of Case Histories of Children with Possible Heart Disease

Case Number	Sex	Age	Years in Pensacola	History of Rheumatic Fever	Murmurs	Cardiac Enlargement	Electro-cardiographic Findings	Previously Suspected
91	M	18	5	Questionable	None	No	1° A-V block	Yes
1,772	F	13	7	Questionable	None	No	1° A-V block	No
1,899	F	14	14	No	LSB	No	PVB's	No
2,130	M	12	11	No	LSB	No	Normal	Yes

Abbreviations used: LSB—left sternal border, and PVB's—premature ventricular beats.

ern Arizona,[14] and Redlands, Calif.[15] It is far less than the incidence in more Northern communities.[8,14,16] The low rate of rheumatic heart disease among the school children examined here is paralleled by a low death rate. Examination of the death certificates of persons under 20 years of age who were residents of Escambia County shows that only 6 white children were reported to have died of heart disease during a five year period (1946-1951). Four of these suffered from congenital heart disease, 1 had rheumatic heart disease, and in 1 the type of heart disease was not specified.

Although the difference in climate in general plays a major role in the variation from locality to locality, the presence of unfavorable living conditions ("micro-climate" of Danisvewsky) will tend to increase the incidence of rheumatic heart disease even in subtropical climates.[17,18] Outbreaks of epidemic rheumatic fever at Naval Training Centers throughout the country during the mobilization of World War II suggest that the "micro-climate" of these centers was at least as important as their location in the occurrence of the disease.[19] It is pertinent to point out that although Pensacola has large sections of substandard housing, the dwellings are usually one or two family types separated from neighboring houses, and there do not exist the overcrowded dark tenements found in more urban communities. In 2 of our 10 cases of rheumatic heart disease, the housing was definitely substandard and in the remainder it was adequate. In 8 of these cases rheumatic fever developed while the child was living in Pensacola.

The number of cases of rheumatic heart disease that we encountered is too small for statistical analysis, but it is of interest that in the 4 cases in which it occurred in boys involvement of the aortic valve, with or without mitral involvement, was present, while in none of the 6 cases occurring in girls were there lesions of the aortic valve. It is also striking that the only case of rheumatoid arthritis in our series occurred in 1 of the 6 girls with rheumatic heart disease.

The incidence of congenital heart disease in the present survey (0.38 per cent) is midway between the extreme of 0.07 per cent reported by Sampson, Hahman, Halverson and Shearer[15] in California, and 0.6 per cent reported in Miami by Saslaw, Ross and Dobrin[13] (table 7). If it is assumed that there is no factor in climate or local environment which affects the incidence of congenital heart disease, the variations reported in the studies listed must be the result of: (1) sampling technic, (2) criteria used, or (3) care with which the study was carried out. Surveys which report unusually low or high incidences of congenital heart disease are therefore liable to critical review. In a given survey, however, the factors which might operate to give a low or high value to the incidence of congenital heart disease should operate in similar direction with regard to rheumatic heart disease. It is thus of interest to calculate the number of cases of rheumatic heart disease for each case of congenital heart disease; in the selected surveys summarized in table 7 the ratio varies from 0.8:1 (Miami, Fla.) to 28.8:1 (Eureka, Calif.). The relative importance of the two varieties of heart disease in a given locality becomes immediately apparent. The variation in the ratio from locality to locality makes it impossible to estimate with accuracy from the inadequate data at hand the proportion of rheumatic heart disease to congenital heart disease for the country as a whole.

Table 7.—Summary of Selected Surveys Reporting the Incidence of Heart Disease in School Children

Location	Author	Number Examined	Incidence of Rheumatic Heart Disease	Incidence of Congenital Heart Disease	Ratio of Rheumatic Heart Disease to Congenital Heart Disease
Montana and Wyoming	Paul and Dixon[14]	688	4.50%	—	—
Salt Lake City, Utah	Young[9]	—	2.70%	—	—
New Haven, Conn.	Paul[16]	1,836	2.50%	—	—
Eureka, Calif.	Sampson and others[15]	2,450	2.00%	0.07%	28.8:1
Denver, Col.	Wedum and others[8]	1,845	1.63%	0.27%	6.0:1
Dublin, Ga.	Quinn[12]	401	1.00%	0.50%	2.0:1
Susanville, Calif.	Sampson and others[15]	—	1.00%	—	—
Salt Lake City, Utah	Alway[10]	1,552	0.70%	0.25%	2.8:1
Miami, Fla.	Saslaw and others[13]	1,001	0.50%	0.60%	0.8:1
Southern Arizona	Paul and Dixon[14]	1,019	0.50%	—	—
Redlands, Calif.	Sampson and others[15]	2,635	0.38%	0.08%	4.8:1
Pensacola, Fla.	Present paper	2,600	0.38%	0.38%	1.0:1

Three cases of probable interauricular septal defects and 3 cases of probable interventricular septal defects comprised the structural congenital abnormalities. We have included 4 cases of Wolff-Parkinson-White syndrome as cases of congenital heart disease, for the most commonly accepted cause of this condition is an anomalous conducting pathway between auricles and ventricles. That most reported cases are in adults rather than in children is probably explained by the fact that most electrocardiograms are obtained from adults. In a large series of electrocardiograms of healthy young men in naval service[20] the anomaly has appeared about once in 700 tracings, an incidence closely comparable to that in this series in school children (1 in 650 cases). Recently reported electrocardiographic studies of infants and children with tachycardia[21,22] indicate that it occurs in the very young and lend support to the thesis that the condition should be classified with congenital heart disease. Not until large numbers of normal children are examined with the electrocardiogram will the actual incidence of this condition be determined. Our 4 cases of the Wolff-Parkinson-White syndrome include 2 in which there were P-R intervals of 0.09 sec. and QRS durations of 0.10 sec. In 1 conduction was normal at irregular intervals. In the other 2 cases short P-R intervals (0.08 sec.) and slurred initial portions of the QRS complex were present, but the total duration of QRS was within normal limits (0.09 sec.). We have considered these cases as variants of the Wolff-Parkinson-White syndrome. In none of these 4 cases was there a history of paroxysmal tachycardia.

Although the present survey uncovered no case of heart disease amenable to surgical correction, the recent increases in the scope, safety and availability of cardiac surgery make the detection of cases of heart disease of more than mere statistical interest. These advances offer an added incentive for school, medical and public health officials to institute more widespread and continuous surveys of the cardiovascular system in school children.

Summary

The materials, methods and criteria used in conducting a cardiovascular survey of the white school children in Pensacola, Fla., are presented.

Twenty-six hundred children were examined, ranging in age from 9 to 23 years and representing 58.5 per cent of all the students enrolled in grades 4 through 12.

Twenty-two cases of organic heart disease were encountered, an incidence of 0.85 per cent. In 10 cases the disease was of rheumatic origin (0.38 per cent), in 10 of congenital origin (0.38 per cent), and in 2 of undetermined etiology (0.08 per cent). Included in the 10 cases of congenital heart disease are 4 cases of the Wolff-Parkinson-White syndrome.

The incidence of rheumatic heart disease is comparable with that reported in other surveys conducted in the Southern part of the United States, and is much lower than the rates reported from Northern areas.

Acknowledgements

We wish to thank the officials of the Florida State Board of Health and the Florida Medical Association, and the members of the Escambia County Medical Society for their active support and interest. The continuous cooperation of the principals, teachers and students of the surveyed schools is gratefully acknowledged. We are particularly indebted to Catherine F. Kasparek, B.A., and Louise V. Sharman, B.S., who not only took all the electrocardiograms and roentgenograms and measured many of them, but who also acted efficiently as receptionists, secretaries and bibliographers. Our thanks are also due to the many hospital corpsmen of the United States Navy who aided in processing the roentgenograms and electrocardiograms.

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A Note on New Drugs, "Miracle" and Otherwise, For Tuberculosis

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The recent dramatic announcement of the new "miracle" drug for tuberculosis was unfortunate from many viewpoints. The newspaper men cannot be blamed, for news is their business, but it was entirely inappropriate for medical men to sponsor a "press conference" that may cause disservice to the patients who are victims of the disease.

First of all, it was premature and unnecessary to tell about a drug of such fantastic repute, months before it could become available, even if every claim proves to be true. Patients always "grasp at straws" and are liable to quit their treatment, call off their surgery and go in search of the "new salvation."

It might be well to point out a few of the possibilities based on past experience. It should be remembered that streptomycin produced favorable effects at first that did not persist. A feeling of exhilaration was experienced by the patient, and in many cases there were decided clinical changes; but there was also a large percentage, perhaps a majority, of cases in which exacerbations occurred, and the patients were saved, if at all, only by strict rest and/or surgery and other drugs. It was necessary to throw many safeguards around the treatment and keep the patient at rest almost the same as before the drugs were used.

Another illustration may be cited to show how illusory may be this old disease. The effect of ACTH and cortisone on advanced tuberculous patients is a case in point. The patients in general not only feel better, but they have ravenous appetites and gain much weight for a while, but the disease progresses on to death. This outcome proves that feeling well does not mean the patient actually is well. The effect of these two compounds on tuberculosis is one of the greatest "Trojan horses" of medicine. It is our duty to watch for others.

Now assuming that the drug is all that is said of it, and that it even kills every tubercle bacillus within its reach, there will be large "abscesses" or cavities in about 70 per cent of the cases, which will need surgery to close them up. The surgery will be increased many fold. Instead of less care in hospitals, there will be more; instead of fewer beds, there will be a need for more, for a while at least, until the present number of cases receive adequate care. This need may last for several years. During this time the case-finding program must go on unabated, or actually be stepped up.

In all probability the drug will fall short of the perfect score that has been reported, and it will have to be handled similarly to other remedies of the recent past. There has not been time enough yet to determine drug resistance or late toxicity.

Finally, there are going to be many errors in diagnosis. Some cases will be complicated by other disease, such as abscess, bronchiectasis, cancer, or mycotic disease, and combination treatment will be necessary, or other treatment, such as surgery, will be the only therapy available. Under any of these conditions, the present methods must still be used to the fullest extent.

A warning to patients and a word of caution to general practicing physicians are incumbent upon all of us who understand better the ancient disease, tuberculosis, so that general panic does not develop in our hospitals, and in tuberculous patients everywhere.

As an anticlimax to this brief discussion, it may be appropriate to point out some of the latest combinations of antibiotics and chemotherapy, so that physicians using antibiotics in the treatment of tuberculosis will be able to obtain a maximum of benefit with a minimum of toxic or other deleterious effects as a result of the treatment.

As to the preference of streptomycin or dihydrostreptomycin, the evidence now seems to point to less toxicity of the latter with perhaps slightly less effectiveness gram for gram than for streptomycin. A gram and a half of dihydrostreptomycin, however, may be given with even less chance of toxic effect than 1 Gm. of streptomycin. Nevertheless, most clinics seem to favor streptomycin, but there is really little difference. Another point

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is that streptomycin and dihydrostreptomycin given twice a week are as effective as when given daily.

The most important recent data[1,2] explain the protection that para aminosalicylic acid (PAS) gives to streptomycin against the development of bacterial resistance and vice versa. One gram of streptomycin twice a week and 12 Gm. of PAS daily, given in four equal doses, have been found to develop only about 15 per cent bacillary resistance for both streptomycin and PAS over a four month period, whereas streptomycin alone will develop about 80 per cent and PAS alone about 50 per cent resistance when given alone during the same period of time.

It is definitely not proper any more, therefore, to give either drug alone because after full resistance develops, further treatment with the particular drug is practically useless. When patients come to the hospitals with resistant bacilli, the treatment is more difficult, and the chances of recovery are greatly decreased. The commonest regimen now is to give streptomycin in 1 Gm. dosage twice a week and PAS in 12 Gm. dosage four times a day.

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Allergy Survey of Florida in the Light of Present Knowledge

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In connection with the preparation of a regional allergy survey of the United States now being undertaken by the University of Illinois, we were asked to bring together current information regarding allergy in Florida. This presented a difficult assignment in several particulars:

1. The aerobiology of Florida has not been fully covered by extended observations.
2. Various observers using different methods and technics have contributed to our still relatively meager knowledge in this field.
3. The correlation between observed allergens and clinical symptomatology is often not demonstrable.
4. Differences in regions of Florida itself are so great that each area merits investigation by itself.

Such a study warrants single or unified over-all supervision and the use of standard, uniform methods. It is our hope that this study may make some contribution to the endeavor and at the same time point up the need for further explorations in this field. The material presented herein is a digest of the work and opinions of representative men in this field gathered by survey based on personal contact and communication.

We have exposed slides daily for over two years, employing a standardized slide holder for pollen capture. The slides are then studied and the daily counts recorded. We have also exposed agar plates both indoors and out-of-doors for twenty minute periods and recorded the resultant mold growth identified later. Some observations have been carried on at other locations, notably at twenty posts of the Florida State Board of Health, Division of Industrial Hygiene, and weather stations under Dr. John M. McDonald, and as regards molds by Drs. Lewis Palay and Nelson Zivitz of Miami Beach. The early studies of the air-borne pollens were pioneered in this state by Mr. O. C. Durham of the Abbott Laboratories, and by Dr. Frank C. Metzger of Tampa. We are happy to make grateful acknowledgment of the work of all of these contributors.

Geography

Florida is primarily a peninsula of low-lying rather flat sandy terrain. It is continually swept

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by winds whose direction and velocity strikingly influence the over-all allergic symptomatology in the area.

Except for the capital, Tallahassee, and Orlando near the center of the peninsula, the principal cities are along the coast, likewise the population centers. Even the largest cities are not classifiable as manufacturing centers. Oil, gas or electricity is used for heating in general. Hence smog is no problem. Despite the abundant rainfall, much fertilization of the soil is needed, and because of the moisture and multitudinous varieties of insects and parasites, spraying of crops, homes and brackish waters adds further complications to those already arranged by nature.

Special Allergy Problems

As a rule pollen counts are low in Florida, especially in the southern two thirds of the state. Patients coming in from other areas note prompt benefit in most instances and it appears to be largely on this quantitative basis. This factor cannot be too strongly emphasized as it is the principal advantage of Florida for the severely grass- or ragweed-sensitive patient from the North and Middle West. This region continues to offer relief to that group of patients, who, over the years, have sung the praises of the state as a hay fever and asthma haven.

Florida deserves special consideration allergically because it affords predominantly an out-of-doors existence. House dust is a problem only during the few winters when the weather may be cold or confining for longer than the usual brief periods. Even so, mold in the dust is more important than the usual linters and other materials, since overstuffed furniture and wool carpeting are less commonly used. Homes are likewise widely open to gusty winds. One also finds sand rather than silt or earth deposits in the accumulated detritus in the homes, and being heavy and larger than the particles of ordinary household dirt, it seldom gets into the circulating air. Being heavy, it even holds down the lighter particles in ordinary dust. Of signal importance is the fact that there is no snow or killing frost in the area except rarely or for short durations.

There is no "quiet period" in the outdoor air. On the contrary, the lush vegetation, the moss and large leaves will hold the pollen grains longer or arrest their flight only to have them picked up by a later gust. The sumacs and ligustrums, the poison oaks and ivies offer abundant contacts for skin irritations. The thunderwood, and, at one time, the manchineel are extremely toxic for humans. Dermatitis from prolonged exposure to muck and the various eruptions from direct parasitic invasion, such as "creeping eruptions," all occur with fair frequency. Skin and respiratory difficulties from exposure to sprays used to protect groves, crops, or nursery plants are encountered several times during any year. Allergy to sunlight is rather less common than the high incidence of exposure here might lead one to expect, and when suspected, porphyria must be ruled out.

In general one might say that in Florida the allergies to inhalants are less explosive or fulminant than in the North, and certainly less than in the Middle West. This difference is perhaps due to the generally lower pollen counts and to the reduced range of temperature changes between the seasons as well as between indoor and outdoor air. Likewise, pollen dosages in treatment go to higher levels generally in order to gain a satisfactory result. "X-hay fever," observed in all the Gulf States, occurs in the fall in Florida and is an often described, little understood clinical entity.

Molds and Pollens

Compared to other areas of the United States, allergically Florida is still relatively "terra incognita." There are so many types of vegetation and pollens, some of the latter insect-borne, and so many varieties of molds and opportunities for their growth and sporulation, that any final appraisal of the air content at this date would be woefully incomplete. Work is in progress to gain fuller information. The puzzling entity, X-hay fever, is not

Table 1.—Principal Pollen and Mold Allergens of Florida

Grasses	Trees
Bermuda	Pecan
Johnson	Oaks
Timothy	Alder
St. Augustine	Australian pine (S. Florida)
Natal	Grounsel bush
Rye	
And others, especially pasturage	

Weeds	Molds
Dwarf ragweed	Aspergilli
Giant ragweed (not in Mid and South Florida)	Monilia
	Mucor
English plantain	Penicillia
Spiny amaranth	Alternaria
Redroot pigweed	Cladosporium
Lamb's quarters	Pullularia
Jerusalem oak	Helminthosporium
Sheep sorrel	Gliocladium
Yellow dock	Fusaria
Water hemp (Acnida cannabina)	Rhizopus
	Streptomyces
Iresine celosia	Torula

yet solved. Wind direction makes a great deal of difference in allergic symptoms, and may be used to advantage in gaining relief for a patient. An easterly wind brings in completely clean air to the East Coast and can be counted on frequently to relieve the ragweed-harassed patient who is sent there for a few days if, of course, he is not too mold-sensitive when indoors.

In the northern districts, pecan pollen presents a seasonal problem in the late winter and early spring. The oaks cause more trouble in northern and central areas, less in the southern districts. Molds are less a problem in the northern and central than in the southern sections and are heavier in summer and early fall in connection with the rainy season. On the coasts, however, and in moist areas mold is always to be reckoned with. Some home owners regularly through the wet seasons, even when hot, light their heaters and run them high for twenty-four to forty-eight hours, in order to "dry out the house." Some of them believe they "lick the mold problem" this way. The various true pines, such as slash and spruce, which pollinate in the spring, have at times been thought to be important offenders, and the pollens appear on slides in some areas in appreciable quantities. There is some clinical correlation, however, with aerial incidence of Australian pine (*Casuarina spp.*) pollen which has been found to be active often enough in the Miami area to warrant its use in treatment. There is the occasional report of eucalyptus sensitivity, and in local areas of sensitivity to mangrove, melaleuca and sea myrtle. Both the leaf and pollen of the Brazilian pepper tree have been considered allergenic.

Summary

The aerobiology of Florida is still relatively unexplored and needs more intensive and extensive study. The counts given in table 2 represent pooled averages and show the low pollen counts for the state as a whole. These low counts make Florida a relative haven for the typical Northern and Midwestern hay fever and asthma sufferer.

A breakdown of the pollen findings by regions into the northern, middle and southern zones with approximately one third of the state in each shows that South Florida has practically no ragweed, some Australian pine and grass pollens, and appreciable quantities of molds. Mid-Florida has less mold, slightly more grass and appreciably larger amounts of ragweed pollen. The oak season is clinically important, while Australian pine is as yet no great problem. The North Florida zone is more like the Southeastern United States in general, with less mold, slightly more ragweed and a heavier tree season, notably pecan.

The entire Florida East Coast, favored increasingly from North to South by a prevailing east wind, shows lower counts, especially in the Miami area. Habitations along the coast, how-

Table 2.—Significant Pollens and Molds in Florida — Season and Counts[1]

Month	J	F	M	A	M	J	J	A	S	O	N	D
Oak	5 +	237 +++	194 +++	27 ++	3 +							
Grasses[2]	16 +	20 +	24 +	65 ++	90 ++	43 ++	58 ++	41 ++	49 ++	32 ++	9 +	3 +
Ragweed					6 +	9 +	27 ++	73 ++	51 ++	21 ++	13 ++	
Amaranth		+ 			+	+	+					
Australian pine	13 +	13 +	40 ++	++	+	+						
Alder	+ 	++ 										
Molds	+ 						+	++	++	++	+	+
All others[3]	102	227	90	51	56	10	15	12	11	6	7	4

1. Based on counts reported from over the state and on twenty statewide observation posts of the Florida State Board of Health, Division of Industrial Hygiene. These estimates are subject to constant revision as further data yielding sounder "averages" are obtained. Plus marks indicate months found and are at best only roughly quantitative.
2. Undifferentiated in counts. Types found are indicated in tabulation of Florida grasses (table 1).
3. Unidentified material including mold spores, smuts and insect eggs and larvae.

ever, are notably moldier. It should be borne in mind that despite fine efforts at standardization, the interpretation of all "counts" is fraught with inaccuracies due to variations in station location, apparatus, counting method, and the observer himself.

In general, Florida is a good area for victims of allergy, not only because of the aforementioned low pollen counts, but because of the reduced temperature ranges found over the state, both as between seasonal extremes and from day to day, likewise from indoors to outdoors throughout the year. This, again, follows the zonal distribution, giving the southernmost area a slight advantage in this regard also.

It is evident from the foregoing, however, that allergy is here to stay. Since we must live with it, it becomes increasingly urgent that from our collective and coordinated efforts we gather a great deal more information about it.

In the preparation of this survey we are grateful for the help of Dr. W. Ambrose McGee, West Palm Beach, Mrs. Babette F. Bernstein, Orlando, Dr. Hal Davison, Atlanta, Ga., and Ronald J. Mann, M.S., New Orleans, La.

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ABSTRACTS OF MEDICAL ARTICLES

Pheochromocytoma: Report of a Malignant Case (Pheochromoblastoma). By Frank J. Pyle. J. Urol. 66:153-162 (Aug.) 1951.

This article contains a brief review of the anatomy, embryology and physiology of the adrenal medulla and a report of a case of malignant pheochromocytoma or pheochromoblastoma. The author states that an adrenal medullary tumor is to be suspected in all cases of paroxysmal hypertension and observes that in difficult cases in which one cannot produce an attack, it may be induced by the injection of histamine, mecholyl or tetra-ethyl-ammonium chloride. He finds the injection of adrenergic drugs such as benzodioxane or dibenamine an extremely valuable diagnostic aid.

Fatalities from Hydrogen Sulfide in Wells. By John M. McDonald, M.D., and A. P. McIntosh. A. M. A. Archives of Industrial Hygiene and Occupational Medicine 3:445-447 (May) 1951.

A tragic incident is recounted which emphasizes the serious toxicity of hydrogen sulfide, encountered mostly as an annoying nuisance in many locations in Southern Florida. This gas often escapes when a pile driver penetrates through filled earth and strikes the underlying mangrove swamp. In vegetable packing plants the wash water from either deep or shallow wells often gives off enough hydrogen sulfide to irritate the eyes of workers alongside the washer. Also, in some open bodies of water, sulfur springs and decaying vegetation combine to produce enough hydrogen sulfide to darken the paint on boats as well as on houses on the shore.

An instance is reported in which the task of cleaning a well, which was part of the water supply of a vegetable packing plant in the Everglades near Lake Okeechobee, resulted in 3 fatalities. The first laborer who went down to shovel mud into the bucket was seen to fall forward in the mud and water at the bottom of the well. Two others who went to the rescue likewise collapsed. The primary cause of death in all 3 cases was given as drowning. Autopsies were not performed. Although it is therefore impossible to estimate the role of hydrogen sulfide in the causation of the deaths, it is known that this gas has a paralytic action on the respiratory center.

The Florida Industrial Commission and the State Board of Health made a combined investigation of the accident. The authors list seven safety precautions for use in cleaning dug wells, which have now been adopted to prevent similar accidents. They also summarize in tables the readings made with M.S.A. type of hydrogen sulfide detector at the time of the investigation and the climatic conditions prevailing at the time of the accident.

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From Our President

Laughter Oils Life's Engine

How would you describe laughter? Is it "a movement of the muscles of the face, especially of the lips, indicating merriment, satisfaction, or derision, and attended by explosive sounds from the throat?" Webster says it is. Dorland's Medical Dictionary defines it as "a series of spasmodic and partly involuntary expirations with inarticulate vocalization, normally indicative of merriment."

Laughter is of the body, of course, but how much more of the spirit? Someone has said: "The sense of humor is the oil of life's engine. No lot is so hard, no aspect of things so grim, but it relaxes before a hearty laugh." So laughter has power, a constructive, driving, uplifting, yes, spiritual power. It can transform the seemingly unbearable into something bearable, even hopeful. It binds men together in a kind of secret free masonry. Haven't you heard it travel around a circle and then noticed that, however large the circle, it becomes forthwith a closed circle? Sometimes it has appeal beyond reason, prejudice and cynicism. Again, it returns a sense of proportion to a troubled mind, for it erases self pity, self justification, self importance.

These are some of the attributes of laughter described by Bob Hope,[1] who surely ought to know. Perhaps its most important quality, he finds, is the ability to bring back the will to live — and, when the time comes, to give one the courage to go with good cheer. What physician at the bedside has not shared the feeling of Charles Lamb, who "jested that he might not weep?"

Too, the famous comedian finds in the power of laughter a kind of geniality that brings mirth and confidence, for "geniality might be defined as strength to spare." What an attribute for the practitioner of medicine — strength to spare, and to share. Thrice blessed is he who spontaneously keeps life's engine well oiled with wholesome laughter.

"The power of laughter," says Hope, "lies in its ability to lift the spirit. For laughter cannot exist with clipped wings. It cannot be dictated to. It must be spontaneous and free as the air you breathe. Thus it is a special property of free men in a free land who are able to laugh at anything . . . or any one . . . especially themselves."

1. Hope, Bob: Why Laughter Has Power, Guideposts (June) 1952.

Robert B McClure

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Dr. Henry Perrine
Versatile Florida Pioneer

When the medical student studying under Dr. Henry Perrine entered their Ripley, Illinois office one evening in 1821 and found that the doctor had taken arsenic with the dose of Peruvian bark he usually took before being exposed to the night air, he was horrified. Carelessly, the student had left the poison in a measuring glass after experimenting with it, and the doctor had poured his medicine into that glass, in the dark, before drinking it. In great haste the student set out after the doctor and overtook him just as he was entering a patient's home a mile or so distant. Vigorous measures undoubtedly saved Dr. Perrine's life, but the incident marked a turning point in his career.

Born in New Brunswick, N. J., on April 5, 1797, a descendant of Daniel Perrin, a French Huguenot who settled in New Jersey in 1665, Henry Perrine had studied medicine in the office of the celebrated Dr. Dewers and at the age of 22 had sought his fortune in the West. A letter written by him on Nov. 15, 1819 from Ripley, Bond County, Illinois showed the fine spirit characteristic of the early American pioneer. Wrote the young doctor to his Uncle Henry:

> . . . Three years ago this county contained but fifteen families; it now has 3000 people. . . . I hope to spend my life [here]. . . .
>
> By all that's free and all that is desirable in freedom, I would rather endure the privations of this country for years, with the prospects I have before me, than to live in Jersey for the same time among comparative conveniences. . . .
>
> Not for a titled equipage
> Not for a slave attendant
> But for the glorious privilege
> Of living independent. . . .

Dr. Perrine did not, however, reckon with the effects of the accidental arsenic poisoning which almost cost him his life. He was confined to his bed for many weeks and later stated that he never fully regained his strength. On Jan. 8, 1822, soon after resuming his practice, he was married to Miss Ann Townsend. In March of the next year, Ann, the first of three children, was born. Not long afterward, his health became so impaired that he moved to Natchez, Miss., in search of a warmer climate. It was there in July 1824 that Hester, the second daughter, was born, and there he suffered a serious illness.

During the two years spent in Natchez, Dr. Perrine began treating malaria with large doses of quinine and hence shared with Dr. Thomas Fearn the honor of being the first to use adequate doses of the drug in treating the highly prevalent malarial fever. In 1826, there was published in The Philadelphia Journal of the Medical and Physical Sciences (4:36-41) an article by Dr. Perrine entitled "Fever Treated with Large Doses of Sulphate of Quinine, in Adams County, near Natchez,

ROYAL PALM AND BANYAN TREE ON THE PERRINE GRANT

THESE INTERESTING PHOTOGRAPHS WERE TAKEN ON THE PERRINE GRANT IN 1876.

Left, a young Royal Palm tree, with fern-like leaves and symmetrical trunk.

Below, a wide-spreading Banyan tree, hundreds of years old at the time the photograph was taken.

Miss." Based on Dr. Perrine's and Dr. Fearn's experiences, the therapy employed by surgeons during the Seminole War in Florida established the efficacy of using large doses of quinine in the treatment of malaria.

Finding that his health could not stand even the cold weather of Mississippi, "the talented little doctor" applied for a consulate in a tropical country. In January 1827 he was appointed United States consul at Campeche, Yucatan, Mexico.

During his ten year stay in Yucatan, he had an attack of both yellow fever and cholera and experienced another dramatic accident which again almost cost him his life. While visiting in the neighboring state of Tabasco, he was invited to attend the Governor's ball. Not having his consular uniform with him, he wore the usual garb of the country. As he leaned over the refreshment table to take a piece of fruit, a soldier standing guard nearby, without a word of warning, thrust his bayonet through his side. With blood flowing freely into his boot, Dr. Perrine stepped up to the Governor and quietly related what had happened. Drawing his sword, the Governor struck off the ear of the guard, ordered him to be imprisoned and summoned medical aid for Dr. Perrine. It is not known whether the valuable gold belts which the Governor presented to Dr. Perrine later were intended to compensate him in part for the accident or to give him recognition for his unusual services as a physician.

Dr. Perrine practiced gratuitously among the poor, and his medical services soon were in great demand. It was said that during a severe cholera epidemic in Yucatan his popularity as a physician became so great that crowds pressed toward him when he appeared, making it difficult for him to drive his carriage along the streets.

It was this popularity, however, which allowed Dr. Perrine to accomplish what no one else up to that time had been able to do. When the Secretary of the Treasury, under the direction of President John Quincy Adams, sent a circular to United States consuls in 1827, urging them to "introduce" into their homeland "all such trees and plants from other countries not hitherto known in the United States," Dr. Perrine appears to have been the only consul who took the directive seriously and attempted to follow instructions. His popularity among rich and poor alike later made it possible for him to secure the seeds of many tropical plants which prior to that time "the priesthood," it was said, had made it impossible to obtain; "or, if obtained, their vitality had been destroyed by having been soaked in boiling water."

In 1832, acting Florida Territorial Governor James Wescott in his message to the legislature stated:

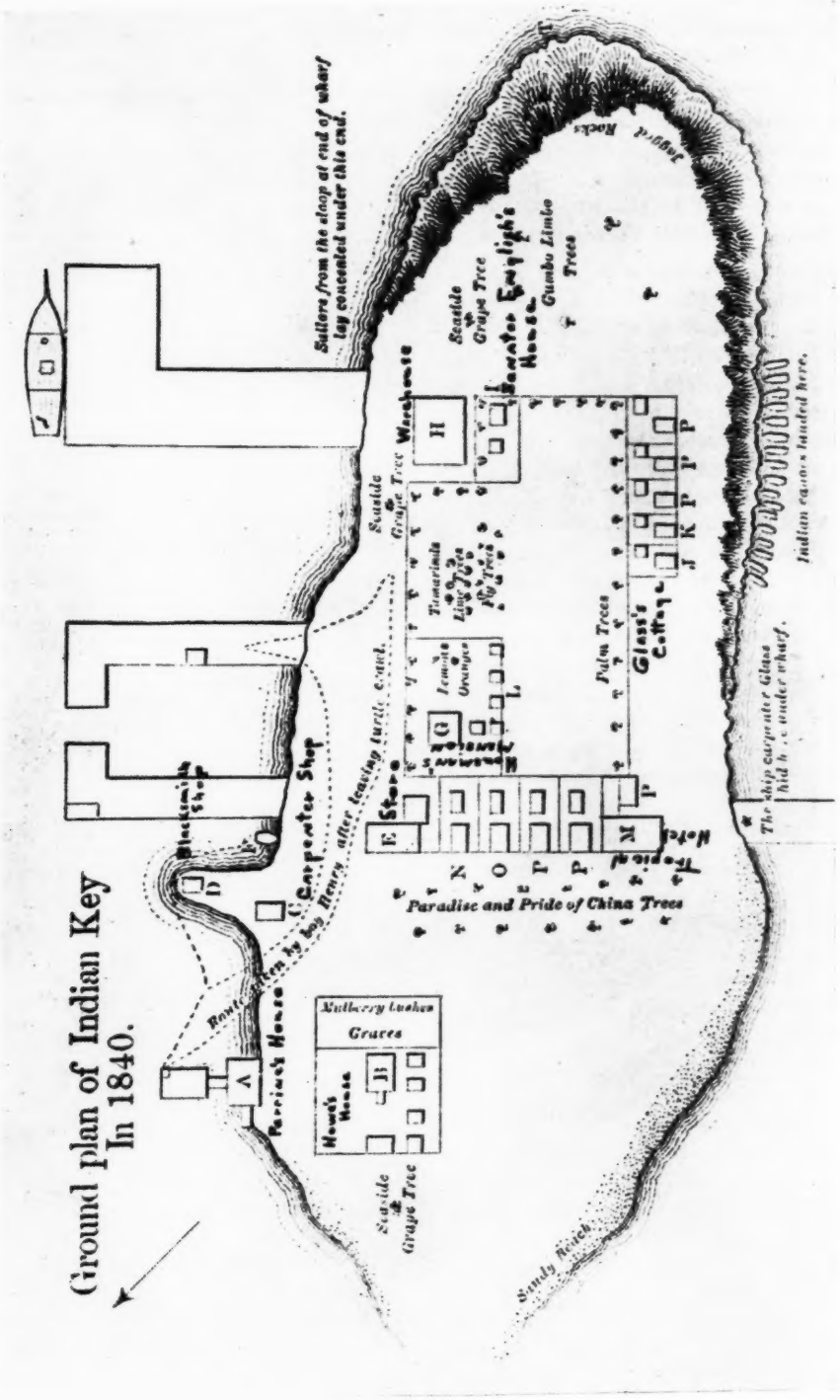
> I herewith transmit to the council. . .an extract of an official letter from H. Perrine, United States consul for Campeachy, to the Secretary of the Treasury. . . . Mr. Perrine is desirous that an act of the council should be passed incorporating himself and his associates into a company for the cultivation of tropical exotics, and he proposes to establish the plantation of the company on the southern part of the peninsula. This enterprise should not be classed with the inflated visionary projects of which Florida has been so prolific. . . . The benefits resulting to the country from the introduction of . . . many valuable foreign products . . . should induce us to render every encouragement and aid in our power to promote the success of the undertaking. . . . I earnestly recommend the granting of a charter as he wishes. . . . The tea plant, . . . the olive, ginger, pepper, cloves, cinnamon, pimento, nutmeg and cocoa . . . could, it is believed . . . be successfully cultivated in most parts of our Territory. If . . . we . . . have more formidable competition in the raising of cotton from Mexico, South America, the East Indies, from Egypt, and from the extensive countries bordering on the Black Sea . . . it is wise for the cotton planter to prepare for the adoption of other articles for cultivation. . . . Whether . . . cultivation of the cane, and the manufacture of sugar, can be relied upon as a certain source of profit to the Florida planter . . . is by many regarded as problematical; but . . . if the experiment fails immediately to yield the planter pecuniary profits, the arguments of . . . independence, and of patriotism, are still in favor of the adoption and culture of every useful exotic congenial to our soil and climate. . . .

The bill was passed by the Florida legislature later in 1832, but land in South Florida was not granted by the Congress until 1838. The official language of the grant is in part as follows:

> Be it enacted . . . that a township of land is hereby granted to Dr. Henry Perrine . . . in the southern extremity of the peninsula of East Fla. . . . one body of 6 mi. square. . . .
> Approved July 7, 1838.

The Perrine Grant is located a short distance south of Miami on Biscayne Bay. The present town of Perrine is located on the original site.

Upon his return to the United States in 1837, the year before the grant was made, Dr. Perrine was given much attention and was widely entertained. Several prominent residents urged him to establish a proposed nursery for useful tropical plants in Louisiana, and he was offered a portion of Lafitte's Island for that purpose. He had by that time, however, become thoroughly convinced that South Florida was the best place to establish a tropical reserve.


Ground plan of Indian Key
In 1840.
Sailors from the sloop at end of wharf lay concealed under this end.
Seaside Grape Tree
Barracks Hospital
Guamba Limbo Trees
Seaside Grape Tree
Warehouse
Tamarinds
Palm Trees
Glass's Cottage
Blacksmith Shop
Carpenter Shop
Store
Hotel
Paradise and Pride of China Trees
Mulberry bushes
Graves
Negro's House
Seaside Grape Tree
Sandy Beach
Indian canoes hauled here.

Dr. Perrine had already corresponded with Mr. Charles Howe, the postmaster and deputy inspector of Indian Key, Fla., and had sent him specimens of the stingless bees of Yucatan. Plants and seeds had been sent to a Captain Dubois at Cape Florida for experimentation. As early as 1833 Dr. Perrine had begun sending plants to a nursery on Indian Key.

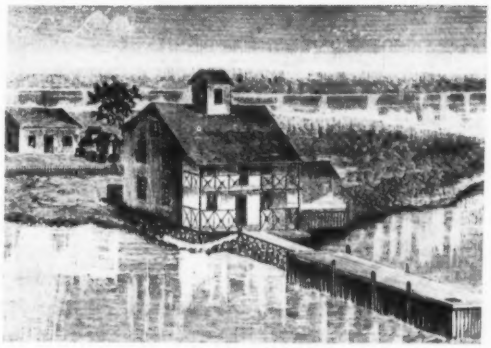
Dr. Perrine's belief that the so-called worthless soil of a section in extreme South Florida would support a large population of small cultivators had been published and apparently discussed widely. After leaving New Orleans, the versatile doctor went to Key West, Fla., by way of Havana, Cuba, and on his way North stopped for a short time at Indian Key. He then went on to Washington to press his claims, after visiting his family in Palmyra, N. Y. En route, he was treated in Charleston, as earlier in New Orleans, as somewhat of a celebrity. From Baltimore on Nov. 6, 1837 he wrote his brother John:

> As my daughters have a taste for music I shall indulge them so far as to encourage their attempts at playing on the piano. I should, however, infinitely prefer that they become adept in drawing and painting, as auxiliaries to the natural sciences, especially to Botany. The drawing and painting of new plants in Tropical Florida will be pleasant and profitable pursuits for our daughters. . . . Painting may perpetuate their memories, and like writing, will enable them to transmit useful intelligence to distant places and future times.

The extent of his labors and the vast fund of information obtained by him as the result of his studies can be appreciated by reviewing the documents which he presented to the Congress. They were published in 1838 at the time of the passage of the Act granting him the township in South Florida.

In the meantime, the Seminole Indian War had begun, and the mainland was not safe for white inhabitants. Setting out with his wife, 11 year old son and two daughters in their early teens, Dr. Perrine arrived on Christmas Day of 1838 at Indian Key, about 30 miles from the mainland, where he believed they could live in safety until the end of the war would permit them to occupy and cultivate the tract on the mainland. This key was the home of the well known and somewhat notorious wrecker, Captain Jacob Housman, who had invested heavily on the 11 acre islet.

Dr. Perrine and his family lived on the tiny island for nearly two years, tending and extending the nurseries begun in 1833. They lived in a



Perrine house and escape tunnel to wharf.

two and a half story house topped by a cupola; its construction was soon to prove all important. There was a small wharf in front of the house. The foundation of the house was built in the water, and the cellar was in reality a bathing pool. Between the house and the wharf there was a connecting dark passageway about 15 or 20 feet in length and about 5 feet in width. Each side was built to the height of four feet with rock, upon which were laid heavy pieces of plank. Over the plank was a covering of rock and then plank again to connect with the wharf proper. This passageway appeared to be of solid masonry, as shown in the accompanying illustration.

In the early days of the Seminole War a small boat was kept in this place of concealment to provide a means of escape in case of attack by Indians at night. As time passed, however, all became lulled into fancied security, particularly in as much as the government had established a station for invalid soldiers on Tea Table Key, a small island about one and a half miles northeast of Indian Key. In 1840, the space under the wharf was being used as a turtle crawl.

Soon after midnight, on the morning of Aug. 7, 1840, members of the Perrine family were awakened by the savage cry of Indians who were approaching their house. Dr. Perrine helped his wife and three children escape through a trap door to steps which led down to the secret tunnel already described. He then called out to the savages, pleading with them and promising them medical assistance if they would stop pillaging and give up their apparent intent to kill and destroy. The family below then heard him retreat toward the upper part of the house and barricade himself in the cupola, the Indians in hot pursuit. There was great noise, then quiet, followed by sounds of

searching the first floor. When the house was finally burned, the doctor's bones were charred and his precious seeds and manuscripts were consumed. Mrs. Perrine and the three children, although nearly cooked, escaped almost miraculously in a boat while the Indians were drinking and pillaging a store nearby.

The doctor's remains were removed the next day by Henry, his son, and the village postmaster, who buried them on Lower Matecumbe Key under a huge sisal, in deference to his love for and intense interest in the species which he introduced.

This tragedy of 112 years ago, all but forgotten now, was news of widest interest at the time. Members of the family were given military escort North and everywhere were greeted with gifts and all forms of attention and sympathy. When their ship arrived in the harbor of St. Augustine, they were greeted by Dr. Peck, Dr. Anderson and Judge Gould, a delegation appointed by the citizens to meet them and tender them the hospitalities of the city. Rooms were placed at their disposal at The Florida House. Wrote Hester Perrine Walker years later:

> We had scarcely arrived when the parlor was filled with ladies and gentlemen, to offer their sympathy and help. When evening arrived, servants with baskets of clothing, began to arrive. . . .
>
> Gov. Reid, had left word, to "be sent for as soon as we arrived" and in the morning he with his beautiful young wife came in such state as became their position — carriage, footman, etc., to tender us the hospitality of their beautiful home.

Dr. Perrine is an excellent example of the courageous pioneer Florida physician who extended the scope of his interests beyond his profession. It is a matter of record that the Perrine Grant, consisting of 23,040 acres, was the first land grant ever made in this country to encourage agriculture. As land promoter and master of political acumen, the doctor won signal recognition from the Congress and might have advanced the development of South Florida by many years had he out-talked the Indians on the night of his massacre back in 1840. The century plants of that region today bear prolific testimony to him as the horticulturist who first introduced foreign tropical plants into the United States and as the botanist who first described the Agave sisalana.

Because of the tragic circumstances of his untimely death at the age of 43, he became to the Army an impelling reason for pressing the war against the Seminoles to a successful conclusion. Distinguished family connections make him important to the genealogist. To the Miamian he is the great-great-grandfather of former Mayor Perrine Palmer, Jr. Some Americans recognize him for his role in the founding of the Smithsonian Institution. But to his patients of more than a century ago he was "the little hard-riding ague doctor."

Unfortunately, there is no photograph extant of this great American whose energy, versatility, perseverance and faith in South Florida cost him his life in the region where some 56 years later Miami was founded. His unusual life story adds a noteworthy chapter to the annals of Florida medicine.

Good Reading for Americans

Whether in medicine, the other professions, business, industry, or any vocation or mode of life, it would appear that governmental red tape has an irksome hampering effect. The testimony of a distinguished business leader, given recently before the Senate Banking and Currency Committee relative to the proposed extension of the Defense Production Act, makes interesting reading to the medical profession. It should interest every citizen. Mr. William J. Grede, President of the National Association of Manufacturers, pleading for restoration of "the function of the free market," explained how controls hinder production and then added:

> Even when prices are below ceiling, which many are, the OPS compliance problem remains. The grind of administrative machinery is still there; the interpretative work of legal counsel is still there; the labors of great corps of accountants and clerks are still there; the time consuming job of analyzing regulations and making reports is still there; the particular situation of customers and suppliers is still there; prospects of new regulations with another new wave of interpretations, analyses, computations, surveys, studies, investigations, determinations, reports, protests and appeals are still there.
>
> These are the difficulties that are tangible, physical and measurable. As they boil and flame in the mind of management, their fusion creates a new substance which is psychological. Its effect is poisonous. It may be described as American psychology thrown in reverse. Confidence is turned into doubt; courage becomes fear, resourcefulness is replaced by caution; planning is turned into waiting; the taking of normal business risks gives way to a drawing-in of all commitments; the sense of freedom is thwarted by a feeling of imprisonment. The dynamic motivation which is the very essence of business progress is stifled.

This graphic portrayal of the governmental shackles hindering business also, as has been well

said, provides a plausible explanation for "the high coronary rate among industrial executives during these crazy times."

How did such times come about? Good reading for you, Doctor, for Mr. Grede, and for every American is Raymond Moley's new book, "How to Keep Our Liberty." Here are elucidated the dangers confronting this constitutional republic from statist attack. Here are traced the trends of the last 20 years, both politically and ideologically, which constitute an ever growing peril to our liberty. Here is presented "carefully reasoned and incontrovertible evidence of socialist thinking and motivation in the present administration's activities in medicine, industry, agriculture, banking, education and other areas."[1] Also, here are proposed positive answers to myriad problems confronting the nation and constructive measures for meeting them within the framework of traditional American liberties.

1. How to Keep Our Liberty: A Program for Political Action, Book Reviews, J. A. M. A. 148:778 (March 1) 1952.

The Changing Disease Pattern

It appears that inability to cope with emotional tensions induced by the strains of modern industrial and urban life is the reason "man has changed his disease pattern more in the last 50 years than in the previous 50,000." He has learned to protect himself against microbes. But has he learned to protect himself against himself? That he has not is evidenced by the fact that three out of the four principal causes of death today are strongly affected by mental and emotional stress.

Addressing a banquet meeting of the Florida Anti-Mosquito Association in Jacksonville recently, Dr. Frank G. Slaughter expressed this basic view of current health problems. He reminded his audience that half a century ago the leading causes of death were pneumonia and influenza, tuberculosis, and dysentery and enteritis. Today, heart disease, cancer and apoplexy take the lead, with accidents ranking fourth. Influenza and pneumonia now occupy fifth place, with other microbe-caused diseases showing similar declines.

In 1840, only 10 per cent of the population of this country was to be found in cities, but a century later, 56 per cent of the people were city dwellers. As society has become more industrial and urban, the greater have become the psychosomatic ills.

The resultant trend is away from individuality and toward the sacrifice of individual freedoms for the sake of security, Dr. Slaughter warned, and added wisely, "Man always pays for this security with loss of his health."

Antituberculosis Drugs

"Wonder drugs" appear to be getting commonplace. This time the information, seemingly prematurely released to the public, concerns antituberculosis drugs. Three isomers of niacin, produced under the trade names of Rimifon, Nydrazid and Marsilid, are said to be effective in the treatment of tuberculosis. These niacin derivatives, reportedly effective in vitro and animals, were used in the treatment of 190 patients "who had not responded to any of the present methods of treatment including . . . streptomycin and PAS . . . and for whom there was no hope . . .," according to an article in the New York Times.[1] Headlined as "Cheap Coal-Tar Synthetics," these new pharmaceuticals were heralded as perhaps reducing the "Cost of Whole Treatment . . . to $100 . . .," although "More Tests Held Necessary."

Both medically and from the viewpoint of cost of therapy, the implications of this news report and others less conservatively and factually written are exceedingly far reaching. It is, therefore, particularly important to keep in mind that even though these compounds may prove more effective and cheaper than any previous ones, reported clinical experience with them in the treatment of human beings is as yet small.

Dr. Henry C. Sweany, Chief Medical Director of the Florida State Tuberculosis Board, in this issue of The Journal explains why it is unfortunate that greater evidence of the clinical effectiveness of these drugs was not available at the time of public release of information about them. He also points out the error of assuming that the public and private institutions now maintained at great expense to combat tuberculosis will no longer be needed even though the new remedies prove to be true specifics against the disease. Nor in his opinion can the social problem presented by tuberculosis be solved so easily as by the advent of new and promising drug therapy.

It is well to keep in mind the impressive triumph for medicine, public health and public education already won in the battle to reduce mortality from this stubborn disease. In recently

published figures showing causes of death in 1951, tuberculosis ranks sixth in a series of six with 17.6 deaths per 100,000, in contrast to cardiac disease, which ranks first with 240.7 deaths. In 1900, tuberculosis ranked first in a series of 10 with 195 deaths, and in 1946 ranked seventh in a similar series.[1] It is hoped, of course, that release of the new compounds to physicians for use generally will bring even greater and more rapid progress.

We are, however, inclined to agree with our New York editorial colleague, who commented: "If nothing is as bad as it looks, it is also true that many things do not prove to be as good as they seem. We hope that jubilation will be confined to the narrow limits of the current small clinical evidence at hand. Northbrooke in 1577 observed that 'One swallowe prouveth not that summer is neare.' "

1. Antituberculosis Drugs, New York State J. Med. 52:1272 (May 15) 1952. New York Times, Feb. 22, 1952.

Periodic Physical Examinations Required

New federal regulations, effective July 1, 1952, raise the physical standards for truck, bus and taxicab drivers engaged in interstate commerce and require periodic physical examinations. In a general revision and tightening up of its safety code, the Interstate Commerce Commission announces the new requirements, which affect an estimated million or more drivers who come under its regulation.

The more important changes of interest to physicians include: 1. After Jan. 1, 1954, every driver must be physically re-examined at least once in three years; currently only a pre-employment physical examination is required. Both employer and employee must have the physician's certificate available at all times. 2. Visual acuity of not less than 20/40 in each eye (with glasses) will be required of new men, but drivers now on the job may qualify under the current standard until Jan. 1, 1954. (Current standard is 20/40 in one eye, 20/100 in the other.) 3. The present requirement of "adequate hearing" will be supplanted by a definite measurement of hearing, which must be met without dependence on a hearing aid.[1] Details may be obtained from the Interstate Commerce Commission, Washington, D. C.

1. Periodic Physical Examinations Required for Interstate Truck, Bus Drivers, Capitol Clinic 3:1 (May 19) 1952.

Pointed Testimony

Dr. Frank G. Dickinson, who directs the Bureau of Medical Economic Research of the American Medical Association, in his recent testimony in Washington before the President's Commission on the Health Needs of the Nation observed that "there has not been to date a realistic study which supports any valid claim that a national doctor shortage is pending." Among the many good points he brought out was this one: "Since people need everything, it can be safely assumed that there are unmet needs for medical services, legal services, dental services, Grade A milk, shoes, and any other goods or services which sell for a price. Since all needs are relative, it follows that all unmet needs are relative. Any approach to the study of regionalization will fail at the start if it is based upon the notion that unmet needs are absolute."

Pointing out that two estimates of the doctor shortage for 1960 have been made in recent years by the federal government, Dr. Dickinson stated that both "assumed a national shortage rather than bothering to prove a national shortage." Many factors, in his opinion, have been ignored in the two studies for making a reasonable estimate of the surplus or deficit in the 1960 supply of physicians.

"What do physicians do for people?" inquired this intrepid investigator. "What would more physicians do for people?"

"The median age of the dying has jumped from age 30 in 1900 to age 67. Volumes are being turned out currently on the social and medical care of the aged. Although a physician must always try as hard to prolong the life of an 80 year old man as he would to prolong the life of a 10 year old boy, the formulation of national policy on the need for physicians must seriously and sympathetically consider the increasing number and percentage of older people — products of medical progress."

1952 Medical District Meetings

"A", Panama City	October 27
"B", St. Petersburg	October 29
"C", Fort Pierce	October 30
"D", Daytona Beach	October 31

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bryson, E. Hampton, Coral Gables
Davis, Harold E., Miami
Gibboney, Harry S., Jr., Ocala
Goldstein, Samuel J., Miami Beach
Light, David S., Miami Beach
Wilber, Stewart A., Jacksonville

YOUR BLUE SHIELD

Doctor's Service Report

All information called for on the Doctor's Service Report is extremely important to the Blue Shield Plan. While some of the information may not appear to be pertinent to the particular case, it should be noted that the Doctor's Service Report serves several purposes.

The main purpose of the Doctor's Service Report is to provide a medium for reporting services rendered Blue Shield subscribers. Perhaps equally important is the statistical use to which the information is put. One of the most important items obtained from statistics is the charges made to the subscriber by the doctor. This allows the Plan to maintain records on the average charges for procedures and, where possible, revise the Schedule of Benefits accordingly.

Complete information on the Doctor's Service Report is necessary and insures prompt disposition of a Blue Shield claim whether or not the claim is to be paid or rejected. Reports that are incomplete require much time-consuming correspondence between the Plan and the physician causing a delay in the final action taken on the case. Immediate disposition of a case is desirable by the Plan and is of the essence to the physician. It goes without saying that the physician benefits by the prompt payment on a Blue Shield case, however, when a case must be disapproved by the Plan and the physician is promptly notified, he benefits by this action, insofar as he is notified in sufficient time to make other financial arrangements with the patient.

The Blue Shield physician can assure himself of prompt settlement on Blue Shield cases, either by the Plan or by the patient in cases where the Plan cannot extend its benefits, by the proper completion of the Doctor's Service Report.

Medical Officers Returned

Dr. John D. Bell, who entered military service in September, 1950, was released from active duty on Oct. 12, 1951, with the rank of Commander, MC, U. S. N. R. His address is 416 Blount Building, Pensacola.

Dr. George H. Anderson, who entered military service on Dec. 1, 1950, was released from active duty on May 2, 1952, with the rank of Captain, MC, USAFR. His address is 176 Fourth Avenue, N. E., St. Petersburg.

BIRTHS AND DEATHS

Births

Dr. and Mrs. J. Q. U. Thompson of Jacksonville announce the birth of a son, John Marcus, on April 5, 1952.

Dr. and Mrs. William H. Mathews of Jacksonville announce the birth of a son, Richard Guyton, on April 10, 1952.

Dr .and Mrs. Thomas Armour, Jr., of Coral Gables announce the birth of a son, Robert Harry, on April 28, 1952.

Dr. and Mrs. Ivan Isaacs of Jacksonville announce the birth of a daughter, Jane Ellen, on May 17, 1952.

Deaths — Members

Hopkins, William B., Tampa	April 27, 1952
Carefoot, George H., Fort Meade	May 3, 1952
Carter, George W., Chipley	May 5, 1952
Richardson, James C., Miami	May 5, 1952

Errata

Information in the June Journal listing the death of Dr. Robert L. Hughes of Bartow is in error.

The Editor Invites Your Contributions on Data of Notable Interest

STATE NEWS ITEMS

The Gulf Coast Clinical Society will hold its annual Scientific Meeting at the San Carlos Hotel in Pensacola, Oct. 16-17, 1952. Speakers scheduled on the program include Dr. Charles Mayo, Mayo Clinic; Dr. Charles Wilkinson, Professor and Chairman of the Department of Medicine, New York University Post Graduate Medical School; Dr. Charles P. Bailey, Charles P. Bailey Thoracic Clinic, Inc., Philadelphia; Dr. Keith Grimson, Professor of Surgery, Duke University, Durham, N. C.; and Dr. Louis T. Byars, St. Louis.

Dr. H. Marshall Taylor, President of the American Laryngological Association, presided over the Seventy-Third Annual Meeting of that organization in Toronto, Canada, on May 23 and 24. While in Toronto, he also attended the annual meetings of the American Laryngological, Rhinological and Otological Society and the American Otological Society.

The Florida Association of Blood Banks held its annual meeting in Orlando May 31-June 1. Dr. Horace A. Day, Orlando, past president, announced that the purpose of the meeting was the standardizing of operational procedure among Florida's 16 blood banks who are members of the association, and to present new developments of interest to the group.

Dr. Robert V. Artola of West Palm Beach spoke on "Noxious Agents Affecting the Nervous System" at a recent semi-monthly meeting of the Licensed Practical Nurses, Division 1.

Dr. Lorenzo L. Parks of Jacksonville, director of the Florida State Board of Health Bureau of Preventable Diseases and Chairman of the Florida Polio Planning Committee, spoke at the annual meeting of the Duval County Chapter, National Foundation for Infantile Paralysis in May.

Dr. Ernest J. Stevens of Orlando has returned to his practice after attending postgraduate courses at the Cook County Graduate School of Medicine in Chicago.

Schedule of the 1952 Medical District Meetings has been announced by Dr. Eugene G. Peek, Jr., Chairman of Council, as follows: "A", Panama City, October 27; "B", St. Petersburg, October 29; "C", Fort Pierce, October 30; and "D", Daytona Beach, October 31.

Dr. Gary E. Turner of Jacksonville was among a group who participated in a panel discussion on Boy-Girl Relationships at the first meeting of the Teen-Age Forum at the Riverside Baptist Church recently.

Dr. Ralph W. Jack of Miami was recently elected vice-president of the Continental Gynecologic Society at the meeting of the Society in New Orleans.

Among the speakers at the weekly basic science lecture program for surgical residents at the Veterans Hospital, Coral Gables, were Dr. Francis N. Cooke of Miami who spoke on "Traumatic Hemothorax," and Dr. John G. Chesney of Miami who spoke on "Carcinoma of the Esophagus."

Dr. Harrien W. Gray of Miami Beach announces the removal of his office to 541 Lincoln Road, suite 401, with practice limited to general surgery and gynecology.

Dr. Herbert Eichert of Miami was one of the speakers at the first Southeastern Heart Disease Control Seminar in Birmingham, Ala., on May 22.

Dr. Carlos P. Lamar of Miami spoke at the meeting of the Dade County Health Council on May 5. His subject was "Geriatrics."

Drs. Julian A. Rickles of Miami and D. Ward White and Herman Boughton of Miami Beach represented the Dade County Medical Association at a symposium on "Self-Examination of the Breast" at St. Francis' Hospital on May 7.

Dr. George F. Schmitt, Jr., of Miami spoke before a group of biology students at the Coral Gables High School recently on "Heart."

Drs. Eugene L. Jewett of Orlando and Ruth S. Jewett of Winter Park left recently for Madrid, Spain, where both gave papers at a meeting of the International College of Surgeons.

Dr. John W. Williams of Lakeland was moderator for a discussion of medical-legal problems held at Morrell Hospital in Lakeland recently. Taking part in the discussion were a group of Polk County lawyers and doctors. Speaking for the doctors were Drs. Edgar Watson, James R. West and Ralph B. Hanahan, all of Lakeland.

Dr. Allen E. Kuester of Cocoa spoke on socialized medicine at a recent meeting of the Kiwanis Club of Cocoa.

Drs. Turner E. Cato and Benjamin G. Oden of Miami spoke in favor of the sewage disposal bond issue before a Bayfront Park audience recently.

Dr. Frances E. M. Read of Jacksonville has resigned as director of the Bureau of Maternal and Child Health of the Florida State Board of Health.

Dr. Francis P. Cassidy of Pensacola spoke at a recent meeting of the Lions Club of that city. His subject was the many advancements in the field of medicine.

A three-day institute on the care of the premature infant was held in the Sellers Auditorium in Jacksonville in May. Among those taking part were Dr. Nathan Weil, Jr., who served as moderator for the round-table discussion on "First Twenty-four Hours of Premature Life," Dr. Camillus S. L'Engle who spoke on "Physiology and Medical Aspects of the Premature Infant," Dr. Luther W. Holloway who spoke on "Common Medical Problems of the Premature Infant," and Drs. E. Frank McCall and Max Suter.

Dr. Paul F. Wallace of St. Petersburg spoke before the Exchange Club of that city recently. He spoke on the need of a county medical examiner.

Dr. Jere W. Annis of Lakeland was chairman of the Polk County Guidance Center's annual fund campaign held during the month of May.

Dr. Thomas H. Lipscomb of Jacksonville has been re-elected representative director of the Duval County Tuberculosis Association on the Florida Tuberculosis Board.

Dr. Alpheus T. Kennedy of Pensacola was guest speaker at a recent luncheon meeting of the Kiwanis Club of Milton. He told the group of some of the symptoms and dangers of cancer and cited the progress that has been made in treating cancer in recent years.

Dr. Douglas R. Murphy of Venice spoke at a recent meeting of the Lower West Coast Blood Bank in Sarasota. His topic was "Recent Advances in Surgery."

Dr. Homer L. Pearson, Jr., addressed a recent meeting of the Woman's Auxiliary to the Dade County Medical Association on the Florida Medical Committee for Better Government.

Dr. James T. Cook of Marianna has been elected president of the Marianna Parent-Teacher Association.

Dr. Robert E. Blount of Fort Lauderdale was a recent guest speaker at a meeting of the Dania Woman's Club. Dr. Blount spoke and showed a film on cancer.

Dr. Richard C. Cumming of Ocala has been named Ocala's "outstanding citizen for 1951," by the Junior Chamber of Commerce.

Dr. Clarence M. Sharp of Jacksonville, Director of the Bureau of Tuberculosis Control of the State Board of Health, was the featured speaker at the third annual dinner of the Ochlockonee Tuberculosis and Health Association in Quincy in May.

Dr. Elwyn Evans of Orlando presented a paper on causes of chest pains and other symptoms that can be mistaken for a coronary heart attack at a meeting of the American College of Physicians in Cleveland recently.

Dr. Phillip W. Horn of Jacksonville was elected president of the Florida Trudeau Society at the Society's convention in Daytona Beach. Dr. Hawley W. Seiler of Tampa was elected vice-president.

Dr. S. Allen Clark of Lakeland was honored by friends and co-workers at a surprise buffet dinner on the occasion of his fiftieth anniversary in the practice of medicine.

Dr. G. Dekle Taylor of Jacksonville has been elected president of the Community Board of the Children's Speech Correction Clinic. He succeeds Dr. Hugh A. Carithers of Jacksonville.

Dr. William C. Roberts of Panama City addressed members of the Practical Nurses Association of Division 5 at a recent monthly meeting.

The new medical building of Dr. Arthur L. Hardie, Jr., of Jacksonville was recently dedicated to the memory of Dr. Robert B. Glenn, who with his wife was killed in in an airplane crash at Key West on April 25, 1951. The dedication took place just one year after the crash.

Dr. James C. Rinaman of St. Cloud spoke on "Mental Health" at a meeting of the St. Cloud Woman's Club recently.

Dr. Frederick J. Waas of Jacksonville spoke on the American Cancer Society's three-phase battle against the disease at a recent meeting of the Sons of the American Revolution.

Dr. Karl B. Hanson of Jacksonville has returned to his practice after taking a week's postgraduate course and attending clinics at Ann Arbor in April.

Dr. Sullivan G. Bedell of Jacksonville spoke on "Music Therapy" at the March luncheon meeting of the Friday Musicale Club of Jacksonville.

Dr. William J. Knauer, Jr., of Jacksonville gave a paper on "Single Medial Rectus Resection as an Initial Procedure for Estropia" at the Eleventh Clinical Meeting of the Wilmer Eye Institute in April.

Dr. James R. Sory of West Palm Beach and J. Champneys Taylor of Jacksonville attended the Fifth American Congress on Obstetrics and Gynecology at the Netherland Plaza Hotel in Cincinnati, March 31-April 4.

COMPONENT SOCIETY NOTES

Columbia

All members of the Columbia Medical Society have paid their state dues for 1952.

Dade

The Dade County Medical Association presented 21 of its past presidents with scrolls in recognition of their services in ceremonies at the Miami Woman's Club in March. Among those cited was Dr. John G. DuPuis, the only surviving charter member of the association and president of the group in 1907.

At the June meeting of the Association, two speakers from Alcoholics Anonymous gave a history of the organization and described their method of handling alcoholics.

Hillsborough

At the regular monthly meeting of the Hillsborough County Medical Association in May, the group voted to become a sustaining member of the Hillsborough County Crime Commission.

At the regular June meeting, Dr. Joseph C. Flynn of Tampa spoke on "Jaundice."

In April, Dr. Osborne A. Brines, professor of pathology at Wayne University College of Medicine in Detroit, addressed the medical staff of the Bay Pines Veterans Hospital and members of the Hillsborough County Medical Association and the Pinellas County Medical Society. His subject was "Cor Pulmonale."

Lake

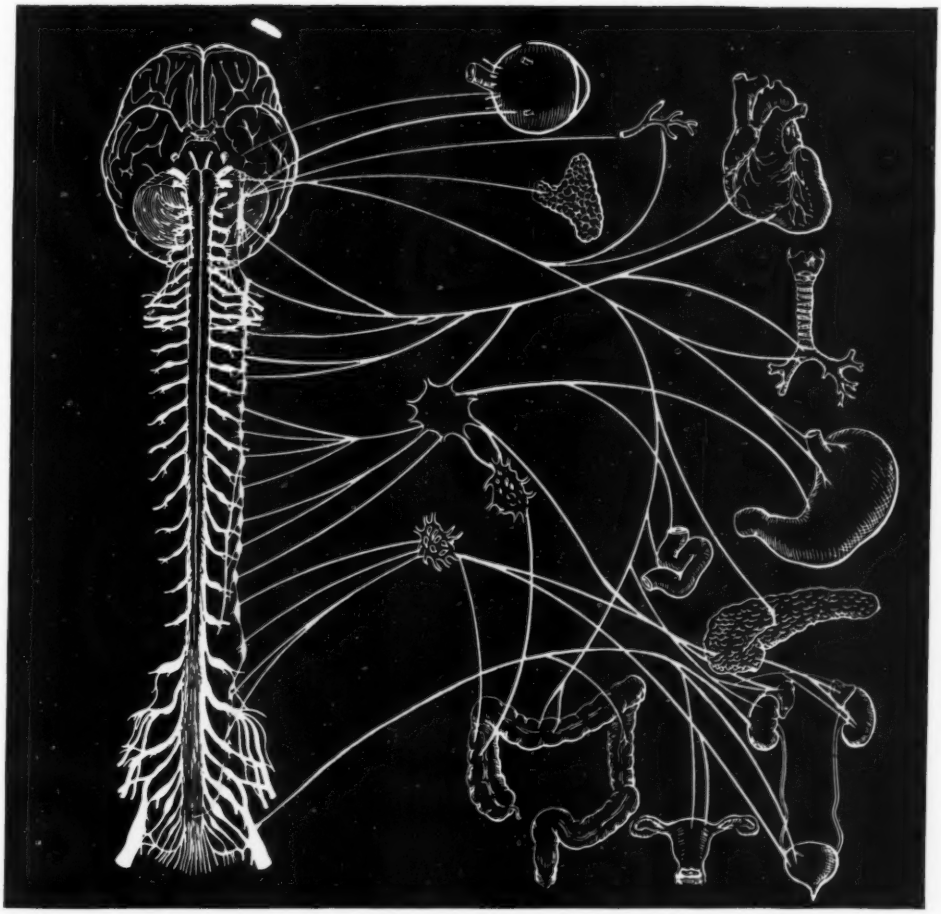
The Lake County Medical Society was host for the Crossroads Cancer Seminar on May 13. Medical societies of five counties were represented among the group attending the Seminar.

(Continued on page 58)

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

PHYSICIAN WANTED: Small central Florida town, near University, 30 miles from hospital. Living quarters available. Assistance in arrangement for office, fixtures, etc. considered for right man. Write: A. B. Rogers, Rogers Pharmacy, Trenton, Florida.



Excess neural stimulation over the parasympathetic subdivision plays an important role in such clinical conditions as peptic ulcer, certain forms of gastritis, pylorospasm, pancreatitis, spastic colon, bladder spasm and hyperhidrosis.

Banthine® Bromide (brand of methantheline bromide) is a true anticholinergic which inhibits parasympathetic stimuli, acting selectively on the gastrointestinal and genitourinary systems. It exerts little or no influence on the normal cardiovascular system. Banthine is supplied in oral and parenteral dosage forms.

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COUNCIL ON PHARMACY AND CHEMISTRY
AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

(Continued from page 56)

Marion

The regular monthly meeting of the Marion County Medical Society was held at the Elk's Club in Ocala on May 20. Several reports were heard, and Dr. Eugene G. Peek, Jr., reported on the meetings of the F. M. A. House of Delegates in Hollywood. It was announced that the next three monthly meetings will be held jointly with the staff of the Monroe Memorial Hospital. Twenty-nine members and their wives were present at this meeting.

Nassau

The Nassau County Medical Society at a recent meeting endorsed the multiphasic survey held in Nassau County, May 28-June 7. This survey presented screening tests covering four diseases of medical importance in Florida. It consisted of a chest X-ray and blood test, which were checked for possible tuberculosis, anemia, diabetes and syphilis.

Pinellas

Members of the Pinellas County Medical Society met with members of the Hillsborough County Medical Association and the Medical Staff of Bay Pines Veterans Hospital in April to hear Dr. Osborne A. Brines, professor of pathology at Wayne University School of Medicine, Detroit, speak on "Cor Pulmonale."

Dr. Chas. L. Farrington of St. Petersburg spoke at the regular June meeting of the society.

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Registered, American Medical Association
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OBITUARIES

John Randolph Perdue

Dr. John Randolph Perdue of Miami died at St. Francis Hospital in Miami Beach on March 27, 1952, after an illness of several weeks. He was 43 years of age. Interment took place in Rocky Mount, N. C., his former home where he was born in 1908.

Dr. Perdue was graduated from Randolph Macon College before receiving his medical training at the University of Virginia Department of Medicine, where he was awarded the degree of Doctor of Medicine in 1932. He then had special training in obstetrics and gynecology at Duke University School of Medicine.

In 1934, a year after his marriage to the former Dr. Jean Jones, a classmate at the University of Virginia, they came to Miami, where they practiced together with offices on Miami Beach. Dr. Perdue rapidly gained prominence as an outstanding practitioner and soon became one of the leading obstetricians of the area. During the 18 years that he practiced in the community, he labored tirelessly in the interests of his profession. At the time of his death, he was chief of staff in obstetrics at St. Francis Hospital and also served on the staff of several other hospitals. He was a life member and had been chairman of the board of directors of the Dade County Blood Bank, and was a member of the board of directors of the Dade County Cancer Institute. A member of the Miami Beach Rotary Club, he also held membership in the Bath Club, LaGorce Country Club and the First Presbyterian Church of Miami Beach.

Long active in the Dade County Medical Association, Dr. Perdue was also a member of the Florida Medical Association and the American Medical Association. He was a founder fellow and past president of the Miami Obstetrical and Gynecological Society, a founder member of the Florida Obstetric and Gynecologic Society, a founder member and past president of the South Atlantic Association of Obstetricians and Gynecologists, and president-elect of the section on obstetrics and gynecology of the Southern Medical Association.

He was also a member of the American Academy of Obstetrics and Gynecology and of the Southeastern Surgical Congress.

In addition to his widow, two children, Jean Duckett Perdue and Terry Randolph Perdue, both of Miami, survive him, and also his father, Randolph Perdue of Rocky Mount.

William Ross Thomson

Dr. William Ross Thomson of Miami Beach died in New York on March 17, 1952. He was 80 years of age. Interment took place in Warsaw, N. Y., his former home.

A native of Florida, Dr. Thomson was born in Pensacola in 1872. He received his medical education at the University of Virginia Department of Medicine and was awarded the degree of Doctor of Medicine in 1896. From 1898 to 1911 he was a member of the New York Medical Society and held the office of vice president in that organization. While he was practicing in Warsaw from 1911 to 1934, he was a member and at one time president of the Wyoming County Medical Society. He was for 20 years a member of the House of Delegates of the Medical Society of the State of New York, and served also as a member of its executive committee and as president of the Eighth District Branch.

In 1934, Dr. Thomson returned to his native state and engaged in the practice of medicine in Miami Beach, specializing in internal medicine. Previously, in New York, he had limited his practice to surgery, but owing to injury to his right arm in an automobile accident in which he was severely injured, he was obliged to discontinue the practice of surgery.

Dr. Thomson was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also a member of the American College of Surgeons.

Surviving is the widow, Mrs. Elizabeth V. Thomson of Miami.

Advertisement

From where I sit *by* Joe Marsh

Whitey Sure "Rang the Bell"

Telephone woke me out of a sound sleep last Friday night about eleven-thirty. "This is Whitey Fisher out on River Road," says a voice. "I just wanted to tell you how much I like this week's *Clarion*."

"Thanks, Whitey," I told him. "But why in blazes call to tell me at this time of night?" "Simple," he says, "your boy just delivered it a while ago. Been waiting for it all evening."

Next day, Buzzy Wilson tells me he delivered Whitey's paper late because he stayed for the school dance and thought it would be OK to drop it off on his way home.

From where I sit, I can't blame Whitey for his joke. He was just reminding me we owe other people the same respect we expect from them. Since I'm always talking about the other fellow's rights—like his right to enjoy a glass of beer and his right to practice his profession without interference, it was only fair that Whitey should "wake me up" to his right to get his copy of the Clarion *on time.*

Joe Marsh

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Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting August 4, August 18, September 8. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting September 8, October 20. Surgical Anatomy & Clinical Surgery, Two Weeks, starting September 22, November 3. Surgery of Colon & Rectum, One Week, starting September 15. Gallbladder Surgery, Ten Hours, starting October 20. Basic Principles in General Surgery, Two Weeks, starting September 8. General Surgery, Two Weeks, starting October 6. General Surgery, One Week, starting October 6. Breast & Thyroid Surgery, One Week, starting October 6. Esophageal Surgery, One Week, starting October 13. Thoracic Surgery, One Week, starting October 20. Fractures & Traumatic Surgery, Two Weeks, starting October 6.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 8, October 20. Vaginal Approach to Pelvic Surgery, One Week, starting Septembr 22, November 3.

OBSTETRICS—Intensive Course, Two Weeks, starting September 29, November 3.

PEDIATRICS—Informal Clinical Course every two weeks.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting July 14. Gastroscopy & Gastroenterology, Two Weeks, starting September 15, November 3.

UROLOGY—Intensive Course, Two Weeks, starting September 8. Cystoscopy, Ten Days, starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 13.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street

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Wagon Train

The annual convention of the Florida Medical Association and its Auxiliary at the Hollywood Beach Hotel was not only a success in every sense of the word relative to accomplishment and production, it was outstanding in that the heart of the operation didn't skip a beat in the shifting of executive authority and committee chairmanship.

There was no evidence of relief on the part of the outgoing leadership or reluctance on the part of the incoming leaders, but merely a shifting of positions and rearrangement of the team which is always a necessary expedient in an uphill climb when the cargo is valuable and the dangers ahead are known.

The convention was as gala as a circus. It had grandeur, color, gaiety, interest. The exhibits, the lectures and business meetings were contrasted pleasantly by outdoor frolic, music and entertainment. It was a great production which took skill, effort, initiative and time to produce. A tribute was paid to the many whose efforts oiled the machinery, provided the props and staged the setting for the annual performance of the Florida Medical Association achievements of the year.

Although the show is over, the work goes on. Maintenance crews are busy examining the construction of the vehicles which they must use to continue up the hill. Plans are being made for the distance they hope to cover and the route is being charted by which they plan to travel.

People are being chosen for their judgment and ability to further the advancement of this caravan of ideals. This requires discretion as well as delicacy for an organization is like a wagon train. The team must be nourished in proportion to the cargo it is expected to carry. Unless we use this grazing period afforded us by the summer inactivity to feed and digest the issues which surround us, it is futile to enlarge our organizational wagon capacity. For no matter how much we take on and hope to carry over the hill, if we are undernourished and inattentive we cannot deliver the goods.

Mrs. C. Robert DeArmas

BOOKS RECEIVED

Surgery and the Endocrine System, Physiologic Response to Surgical Trauma — Operative Management of Endocrine Dysfunction. By James D. Hardy, M.D., F.A.C.S. Pp. 153. Price, $5.00. Philadelphia, W. B. Saunders Company, 1952.

In this monograph, the author accomplishes well his twofold objective. First, he outlines the mechanisms by which the patient survives injury and clarifies for the general surgeon ways in which certain recent advances in physiology affect surgical care. In indicating the physiologic bases upon which intelligent management may enhance the capacity of the patient to withstand surgery, he recognizes the very considerable part which the endocrine organs play in mobilizing and transporting the metabolic reserves in an emergency.

Chapters 1 through 6 are devoted to a resume of the alarm response; the large influence which the hormones exercise in the regulation of the metabolism of body fluids and in shock; certain physiologic aspects of nutrition and ways in which the nutritional status of the patient may affect his capacity to withstand trauma; the physiologic consequences of prolonged bed rest and a rationale for early ambulation; the importance of endocrinology in the fields of infection, tissue repair and regeneration, and neoplasia; and endocrine therapy in surgical patients. In these fields, all of which are in their infancy, Dr. Hardy assembles all available material which can be accepted at this time and also presents excellent bibliographies.

His second objective is to present the facts and procedures he considers most useful in the management of surgical diseases of the endocrine organs. In bringing together those special problems which are of particular interest and importance to the general surgeon, he devotes chapters 7 through 11 to surgical problems related to the thyroid, parathyroids, pancreas, adrenals, pituitary, thymus, ovaries and testes.

This book covers a wide variety of subjects, many closely interrelated, and all of daily concern to the surgeon. It is not a handbook of preoperative and postoperative care. It is, however, a volume which provides the physiologic basis for many types of surgical therapy.

Annual Report on Stress. By Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada). Pp. 511 (133 R). Price, $10. Montreal, Canada, Acta, Inc., 1951.

This Annual Report on Stress is a treatise designed to fulfil the dual task of serving as a guide to the entire literature on stress and as a critical correlator of pertinent facts. It is presented as the first annual supplement to "Stress" ("Stress — The physiology and pathology of exposure to stress, a treatise based on the concept of the General-Adaptation-Syndrome and the Diseases of Adaptation" by Hans Selye, Acta, Inc., Medical Publishers, Montreal, Canada, 1950), but scrupulously avoids duplication of material already presented in that monograph. Each section, however, is written as a complement to the corresponding section of "Stress."

This volume, uniquely and conveniently arranged, sets the pattern for the Annual Reports on Stress in that it presents an extensive classified index of pertinent new facts and a concise textbook-like evaluation of the principal findings. It deals with some 3,000 references to articles almost all of which were published in the academic year immediately preceding publication.

This attempt at critical evaluation of newly acquired data and its prompt integration into the body of classical knowledge should greatly promote progress in this new subject which has already made impact upon almost every aspect of medicine. Within the comparatively short span of the last fifteen years, during which the stress concept has taken shape, and particularly during the last two years since ACTH and cortisone have become generally available, most physicians have decided to read up or experiment on some facet of this subject. Annual reports from the pen of Dr. Selye on the scale of this one should be most helpful in expediting this study.

Dynamic Psychiatry, Basic Principles. By Louis S. London, M.D. Pp. 98. Price, $2.00. New York, Corinthian Publications, Inc., 1952.

Designated Volume One, this book contains five chapters: The Evolution of Psychotherapeutics; The Meaning of the Dream; Psychology of the Libido; The Development of the Libido in the Child; and The Libido in the Adult.

After some fifteen years on the staffs of several of the largest mental hospitals in New York State, the author spent several years in intensive postgraduate study in neurology, psychiatry and psychoanalysis in Vienna. During the past twenty years he has been a consultant and engaged in private practice in New York City and Washington, D. C.

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* Lane, C. G., "Therapeutic Dermatitis", New Eng. J. Med., 246:77-81, 1952
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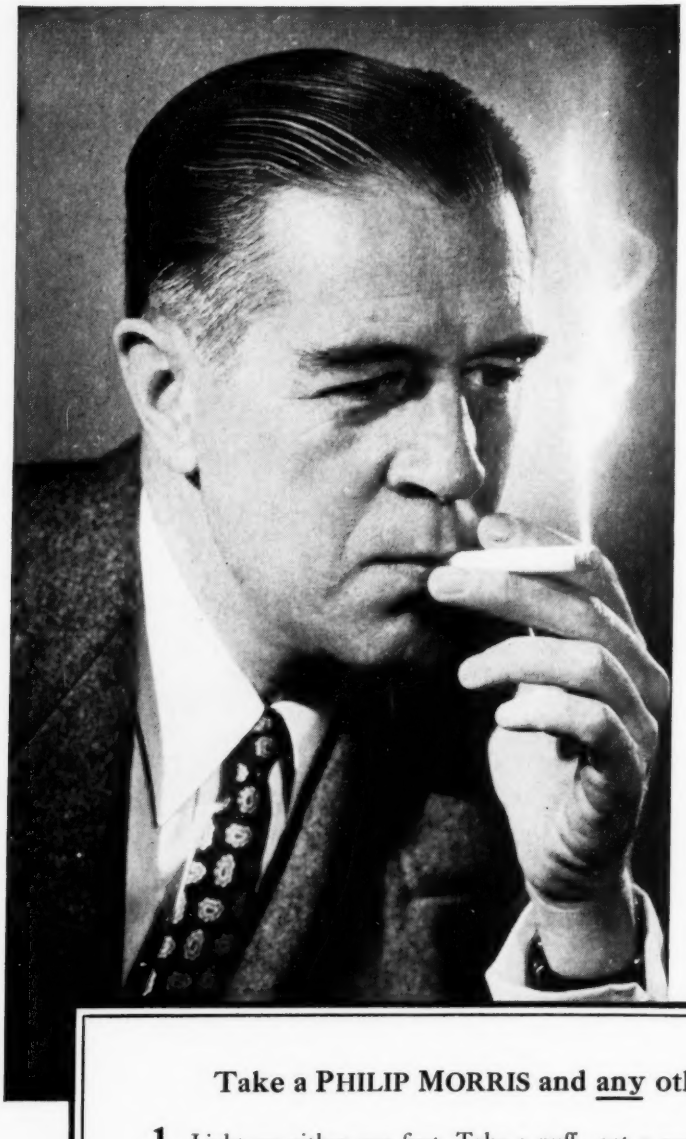

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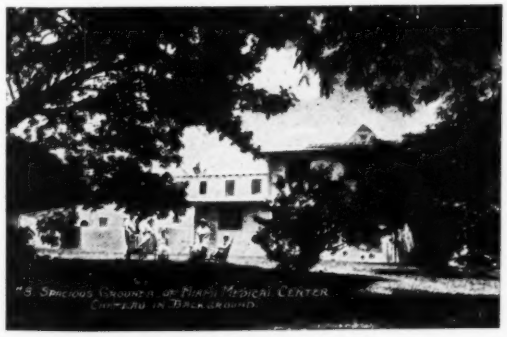
SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Florida Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
A-Northwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Panama City, Oct. 27, '52
B-Northeast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	Daytona Beach, Oct. 29, '52
C-Southwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	St. Petersburg, Oct. 30, '52
D-Southeast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	Ft. Pierce, Oct. 31, '52
Florida Specialty Societies			
Academy of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Allergy Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
Anesthesiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
Chapter, Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
Derm. and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Health Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
Industrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
Ophthal & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
Pathologists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
Pediatric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
Proctologic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
Radiological Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
Urological Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
Blood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
Blue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 26, '53
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
Dental Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
Heart Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
Hospital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
Medical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
Pharmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
Public Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
Tuberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	
Woman's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
American Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	
A.M.A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
Southern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
Alabama Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
Georgia, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
S. E. Hospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
Southeastern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
Southeastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Havana, Cuba, Mar. 26-29, '53
Southeastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
Gulf Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct. 16-17, '52



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					Total	Paid	
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	21	
	Escambia **Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	75	70	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	7	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
	Columbia **Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	58	53	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	9	100%	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor **Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	233
B	Alachua **Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	48	
	Duval **Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	254	228	
	Marion **Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	30	26	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	10	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake **Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	25	B-4-53 Eugene L. Jewett, M.D. Orlando
	Orange **Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	153	141	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia **Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	80	79	667
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	173	153	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	16	
	Pasco-Hernando-Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	17	16	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	191	186	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee-Highlands-Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte-Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett F. Martin, M.D. Haines City
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	90	82	584
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	115	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	12	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	82	72	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	602	524	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	13	12	836